North Carolina Institutional Bias Study Combined Report

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I. INTRODUCTION AND STUDY GOALS

North Carolina offers an array of long term care (LTC) services for Medicaid beneficiaries, ranging from in-home supportive services to community supports to nursing facilities. In 2004, House Bill 1414 (HB 1414) directed the state's Department of Health and Human Services (DHHS) to commission a study of whether an institutional bias exists in Medicaid-financed LTC services.[1] HB 1414 further directed that for any identified institutional bias, recommendations regarding steps to ameliorate any bias be provided. **In this study, the term "institutional bias" refers to federal or state policies, state administration and the local operations and practices related to Medicaid that favor the choice of institutional care over services in home and community-based settings from the individual's perspective.** DHHS is required to report the results of the study to the North Carolina Study Commission on Aging.[2]

In 2001, North Carolina's Institute of Medicine (NCIOM) presented a General Assembly-commissioned report to the incoming DHHS Secretary Carmen Hooker Odom entitled "A Long Term Care Plan for North Carolina." The report outlined barriers in state LTC policy and practices and offered recommendations to the State on how to improve the LTC delivery system. This 2005 study builds on those findings and recommendations and offers an updated look at North Carolina's Medicaid LTC system.

The study considers all in–home services paid under the State's Medicaid program, including the Community Alternatives Program for Disabled Adults (CAP/DA) waiver services, home health, and personal care services provided in both adult care homes and individuals' residences, as well as nursing facility services, and focuses on Medicaid LTC programs for older adults and adults with physical disabilities. While it is possible to draw some conclusions for other populations, the service delivery systems and policies for older adults and adults with physical disabilities differ considerably from systems and policies for persons with mental retardation or developmental disabilities and severe mental illness. Given the study population, nursing facility care is considered institutional while CAP/DA, home health and personal care services were considered non-institutional.[3] The following home and community-based (HCBS) waivers were not considered in this study: CAP/AIDS for persons with HIV and AIDS; CAP/MR for persons with mental retardation; and CAP/C for children.

Institutional bias can be present in different areas of the LTC system, including access to services, the amount of services covered and their limitations, rate-setting, the availability and affordability of providers in institutions and in the community, and the quality of LTC services. In addition, there are environmental factors outside of the Medicaid program that can impact institutional bias, such as the availability of affordable, accessible housing and transportation

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1 House Bill 1414 (Session 2003), Section 10.13, General Assembly of North Carolina. Available at: http://www.ncga.state.nc.us/Sessions/2003/Bills/House/HTML/H1414v7.html.

2 The Commission consists of 17 members. Of these members, eight are appointed by the Speaker of the House of Representatives, eight are appointed by the President Pro Tempore of the Senate, and the Secretary of the Department of Health and Human Services or the Secretary's designee serves as an ex officio, non-voting member.

3 Although some argue that adult care homes should be considered institutional, statute defining adult care homes as assisted living residences and the Request for Proposal for this study identified Adult Care Homes as a home and community-based service (Exhibit 1, Page 3).

for older adults and persons with physical disabilities. The focus of this study is primarily Medicaid policies and practices.

To inform the analysis, the Lewin team conducted a desk review of pertinent policies governing North Carolina's Medicaid LTC benefits including the North Carolina Administrative Code, the Medicaid State Plan, the CAP/DA Waiver, provider education materials, and utilization review contractor policies and procedures. This was supplemented by in-person interviews with key informants in April 2005. Lewin conducted interviews with 19 state agency staff and conducted meetings with 18 consumers and 18 providers to assess the day-to-day application of policies and regulations. A list of participants is included in ***Appendix A***. Lewin also initiated telephone follow-up with selected interviewees. Finally, DMA provided data for the Medicaid long term care services targeted for analysis.

Lewin evaluated North Carolina in the context of other states to provide a benchmark for comparison of North Carolina's Medicaid program's policies and practices and areas of institutional bias. To inform the study, Lewin conducted interviews with staff in Florida, Georgia, and New York and evaluated how North Carolina compares to these states with respect to the nature, extent, and results of institutional bias. These states were chosen for their similarities to North Carolina in terms of: 1) geographic proximity to North Carolina (Florida and Georgia); 2) size of the Medicaid population (all three comparison states); and 3) a large personal care program (New York).

The remainder of this report is organized as follows:

- Section II provides an overview of long term care and North Carolina's long term care system
- Section III provides Lewin's findings regarding biases in North Carolina's Medicaid long term care program, our recommendations to ameliorate the biases and an explanation of both for the following areas:
  - Medicaid long term care benefits– the medical criteria and necessity rules and practices, and the amount, scope and duration of mandatory and optional benefits
  - Long term care availability and accessibility– the Medicaid income and financial eligibility rules, eligibility process, and medical/functional assessment and care planning; the process for accessing long term care services, and provider capacity
  - Cost containment practices– a variety of measures to manage costs including prior approval, spending caps, utilization management, and case management; rate setting
  - Long term care provider regulation and oversight– the different mechanisms in place to assure quality in long term care, including facility and personnel licensing and certification, utilization management, and prior approval
- Section IV concludes the report.

II. OVERVIEW

A. Long Term Care Institutional Bias and *Olmstead*

Long term care consists of a range of medical and social supports provided to individuals with chronic illness or disabling conditions at home, in the community, or in institutional settings. While most long term care is provided by family and other informal support, Medicaid represents the largest public payer and expenditures on long-term supports constitute nearly one-third of states' Medicaid budgets.[4] State Medicaid programs play a significant role in efforts to reform long term care systems and ensure adequate management of costs, quality and access to care.

In this study, the term "institutional bias" refers to federal or state policies, state administration and the local operations and practices related to Medicaid that favor the choice of institutional care over services in home and community-based settings from the individual's perspective.

Under federal Medicaid law, states must cover the cost of nursing facility care for all eligible beneficiaries (federal mandatory benefit), but are not required to provide LTC services in community settings (except for home health services which primarily focus on post-acute care). To provide alternatives to institutional care, in 1981 Congress authorized the use of Medicaid Home and Community-Based Services (HCBS) waivers to allow states to serve individuals with LTC needs through home and community-based services not otherwise Medicaid reimbursable under a Medicaid State Plan. Waivers must be approved at the federal level, but provide states with vast flexibility in determining who to serve, the scope of services, and where and how those services are delivered. Today, all states except Arizona use HCBS waivers as part of their Medicaid programs.[5] In addition, states can choose to provide personal care services (PCS) as a state plan option. States that choose this course cannot restrict the services in the same manner as they can with waivers because the PCS benefit must be available to anyone eligible for Medicaid. However, states may limit the PCS benefit through two mechanisms: "medical necessity" and "utilization control" (e.g., number of hours allowed). Thirty-five states, including North Carolina, opt to make personal care services available through their state Medicaid plans.[6]

The steady increase in the number of HCBS waivers and personal care services provided has contributed to a corresponding reduction in the reliance on nursing facilities in the states.[7] In FY 1992, home and community- based services expenditures (including waiver expenditures, personal care, and home health) accounted for only 14.8% of the total Medicaid LTC spending

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4 Burwell, Brian, Sredl, Kate, and Eiken, Steve, *Medicaid Expenditures for Long Term Care Services: 1992-2004*. Published May 11, 2005.

5 Arizona operates its entire Medicaid program using a Section 1115 Medicaid demonstration waiver and includes a range of home and community based care options using that federal authority.

6 Burwell, 2005.

7 The Centers for Medicare and Medicaid Services. *Home and Community-Based Services Program Information, Summary Report*, Nov. 4, 2003. Available at: www.cms.hhs/gov/medicaid/1915c/proginfo.asp.

in the U.S., but by FY 2004, home and community-based expenditures accounted for over 35.5% of the total Medicaid LTC spending in the U.S.[8]

While states made great strides in increasing community options during the 1980s and 1990s, the U.S. Supreme Court's *Olmstead v. L.C.* decision in 1999 provided further motivation for states to restructure their programs to allow Medicaid beneficiaries to receive services in the most integrated settings possible.[9] In the *Olmstead* decision, the Supreme Court held that states may be violating Title II of the Americans with Disabilities Act (ADA) if they require individuals with disabilities to be served in institutions rather than in more integrated community settings, if appropriate. The Court suggested that states could defend themselves against lawsuits by having in place a "comprehensive, effectively working plan" for moving qualified disabled individuals to less restrictive settings. The Olmstead ruling does not call for the elimination of institutions, but rather the elimination of unnecessary and inappropriate use of institutional care and fair access to the least restrictive setting. The court also included a reasonable cost constraint, indicating that integrated community settings would be required "unless the State can prove that requiring it to make these additional expenditures would be so unreasonable given the demands of the State's mental health budget that it would fundamentally alter the service it provides."[10] North Carolina has adopted an "*Olmstead* Plan."

B. Overview of North Carolina LTC

Within the North Carolina Department of Health and Human Services, publicly-financed LTC services for older adults and adults with physical disabilities are administered through several divisions, including the Division of Medical Assistance (DMA), the Division of Aging and Adult Services (DAAS), and the Division of Vocational Rehabilitation Services. DMA operates the State Medicaid program including the state's Medicaid Home and Community-Based Services waivers, known as the Community Alternatives Program (CAP), and personal care services.[11] The Division of Aging and Adult Services administers the federal Older Americans Act programs, including oversight of the state's 17 Area Agencies on Aging (AAAs) and programs for older adults and persons with physical disabilities funded by the NC General Assembly. The Division of Vocational Rehabilitation Services provides a variety of services to persons with physical or mental disabilities in order to help them become independent or job-ready.

The North Carolina Medicaid program purchases the majority of LTC services in the state. As such, the Medicaid program has sought ways to provide sufficient services to all beneficiaries requiring long term supports in institutional settings, community settings such as adult care homes, and individuals' own homes.

Long term care is a critical issue for North Carolina for three key reasons:

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8 Burwell, Brian, Sredl, Kate, and Eiken, Steve, *Medicaid Expenditures for Long Term Care Services: 1992-2004*. Published May 11, 2005. Includes long term care spending for all populations, including MR/DD.

9 Olmstead, Commissioner, Georgia Department of Human Resources, et al. v. L. C., (98-536) 527 U.S. 581 (1999).

10 Ibid.

11 North Carolina Institute of Medicine, Community *Alternatives Program for Disabled Adults (CAP/DA):2003. A report to the NC General Assembly*. Durham, NC: February 2003.

- Spending on all LTC services in SFY2005, both in institutions and in home and community-based settings, constituted one-third of the Medicaid budget (32.9%).[12] Both utilization (the number of services used) and the underlying cost of providing LTC services, which often involve a combination of skilled medical care and intensive, frequent supportive care, contribute to the disproportionate spending on these services relative to the number of individuals served.

- Older adults and persons with disabilities—those most likely to use LTC services— will significantly increase in number over the coming decades contributing to increased demand for and spending on LTC.

- In response to the Olmstead decision, North Carolina, like other states, has actively focused on providing care for persons requiring LTC services and supports in the least restrictive setting possible.

Medicaid funds a mix of community-based long term care services in North Carolina that includes a substantial personal care program that supports many individuals living in adult care homes as well as their own homes, the CAP/DA waiver program, and home health services.

1. North Carolina's Medicaid Long Term Care Services

All states that participate in Medicaid are required to offer certain "mandatory" benefits to all Medicaid beneficiaries, although beneficiaries may need to meet certain functional or medical criteria. These include inpatient/outpatient hospital care, physician services, laboratory and x-ray services, immunizations, and health center/rural health clinic services. ***Mandatory*** long term care services include:

- **Nursing Facility Services** -- Nursing facility services provide 24 hour nursing supervision and include room and board, therapeutic leave, non-prescription drugs, biological serums and vaccines, physical therapy, speech pathology, occupational therapy, diagnostic services, social services related to the resident's physical, mental, and psychosocial well being, activity services to meet physical, mental, and psychosocial needs, personal laundry, routine room, dietary, medical and psychiatric services, medical supplies, personal hygiene items, medical equipment (canes, walkers, etc.), and dietary supplements.

- **Home Health Services** – Home health services include part-time or intermittent nursing services provided by a home health agency, home health aide services provided by a home health agency, personal care, medical supplies, equipment, and appliances suitable for use in the home.

[12] Unpublished Medicaid data for State Fiscal Year 2005 provided by the North Carolina Division of Medical Assistance, November 2005. Note: LTC includes skilled and intermediate care nursing facilities, hospital long term care, home health, durable medical equipment, Community Alternatives Programs, home infusion therapy, hospice, personal care services, and adult care home services.

Appendix B contains more detail regarding the array of institutional and home and community-based services in North Carolina.

States may choose to cover optional benefits through their Medicaid State Plan. Optional services include prescription drugs, hospice, dental and vision care. ***Optional*** state plan long term care services include:

- **Personal Care Services** -- PCS are personal aide services provided in private residences or other locations in the community, such as Adult Care Homes, for individuals who have a debilitating medical condition. PCS includes assistance to patients to help perform certain tasks such as eating, bathing, dressing, toileting, transferring, personal hygiene, light housework, and medication management.

    - **In Home – PCS --** Eligible individuals residing in private residences may receive no more than 3.5 hours per day and a total of 60 hours per calendar month of regular PCS. North Carolina also offers "Personal Care Services- Plus" or PCS Plus for people with more intense care needs. PCS Plus offers up to an additional 20 hours of PCS per month.

    - **Adult Care Home – PCS --** Adult Care Home (commonly referred to as an Assisted Living or Family Care Home) is a category of facility that provides 24-hour supervision and services for people needing assistance with activities of daily living (ADLs) due to normal aging, a chronic illness, a cognitive disorder, or a disability. People in adult care homes receive help with personal care, such as dressing, grooming, and medication management, and require limited supervision and do not need medical intervention. Those eligible for extra care as an "enhanced care" resident may receive extensive or total assistance in ambulation/locomotion, toileting and/or eating. PCS in adult care homes is paid at a daily rate and does not have a limit on the number of hours of personal care provided. However, reimbursement is based on only slightly over one hour per resident per day.[13]

- **Private duty nursing (PDN)**: PDN provides services to beneficiaries who require individualized, continuous, substantial, and complex nursing interventions not available through regular nursing services.

- **Hospice**: Hospice is a service provided to individuals who are in the final stage (six months or less) of their lives due to a terminal illness. Hospice focuses on palliative care and symptom management as opposed to aggressive, curative treatments. Hospice services can be provided at home, in a nursing facility, hospice facility, or hospital. Hospice is covered for two 90-day periods, followed by an unlimited number of 60-day periods.

[13] Adult Care Home Cost Modeling Committee, *Report of the Findings and Recommendations of the Adult Care Home Cost Modeling Committee*, May 2005. http://www.dhhs.state.nc.us/ltc/ACHCostModelReport.pdf

Finally, states can obtain "waivers" of the federal law to offer certain benefits to a subset of the Medicaid population. Specifically, states can use Home and Community-Based Services (HCBS) waiver authority to receive federal Medicaid funds to provide services that are not otherwise reimbursable under the Medicaid State Plan.

In North Carolina, home and community-based waiver services are offered as an alternative to institutions through the **"Community Alternatives Programs" (CAP)**. There are several CAP programs for adults with physical disabilities, including Community Alternatives Program for Disabled Adults (CAP/DA), Community Alternatives Program for Persons with AIDS (CAP/AIDS), and Community Alternatives Program/Choice (CAP/Choice).[14] This report focuses on the CAP/DA program, which is the largest waiver program for the study population.

CAP/DA provides a package of services to allow adults (age 18 and older) who qualify for nursing facility care to remain in their home. The program is designed for individuals who currently live in a private residence and are at risk of nursing facility placement or those who currently live in a nursing facility and desire to return to a private residence. Individuals on the waiver: 1) require CAP/DA services to live at home; 2) can have his/her health maintained at home within Medicaid cost limits, and 3) desire CAP/DA services instead of institutional care. CAP/DA has two levels of care – intermediate level of care and skilled level of care, with different budget limits per month; approximately 86 percent of CAP/DA participants require intermediate level of care.[15] Benefits include case management, adult day health services, and in-home aide services, such as housekeeping, laundry, essential shopping, personal assistant services, medical and personal care supplies, home modification (wheelchair ramps, safety rails, grab bars), home delivered meals and nutritional supplements, respite care, and telephone alert services. The CAP/DA plan of care must receive prior approval by DMA, or the local lead agency authorized by DMA.[16]

North Carolina also offers supplements to the federal Supplemental Security Income (SSI) payments, called **State/County Special Assistance (SA)**, to help pay for room and board of qualifying residents of adult care homes and a limited number of individuals in their own homes who meet the ACH level of care. These benefits use eligibility criteria parallel to the Medicaid program and those who receive this SA also become eligible for Medicaid. As the name suggests, the program is funded in part by the state and in part by the counties; each contributes 50 percent to the pool of funds available.

The Special Assistance Adult Care Home program is an entitlement, so the state and county are responsible for making payments for every eligible individual. Individuals must be over the age of 65 or between the ages of 18 and 65 and disabled under Social Security Administration guidelines to receive SA payments. Adult care home residents who qualify for SA are automatically eligible to receive services under the Medicaid program. In adult care homes, the

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[14] North Carolina has two additional waiver programs -- the CAP/MR program targets individuals with mental retardation and the CAP/C program that targets children with special health needs.

[15] Perrin, Lynne. *North Carolina's Community Alternatives Program for Elderly and Disabled Adults,* Presentation at the 21st National HCBS Waiver Conference, May 16, 2005. Available at: http://www.nasua.org/waiverconference/hcbs2005/9%20Lynne%20Perrin.ppt

[16] Lead agencies are selected by County commissioners to administer the CAP/DA program.

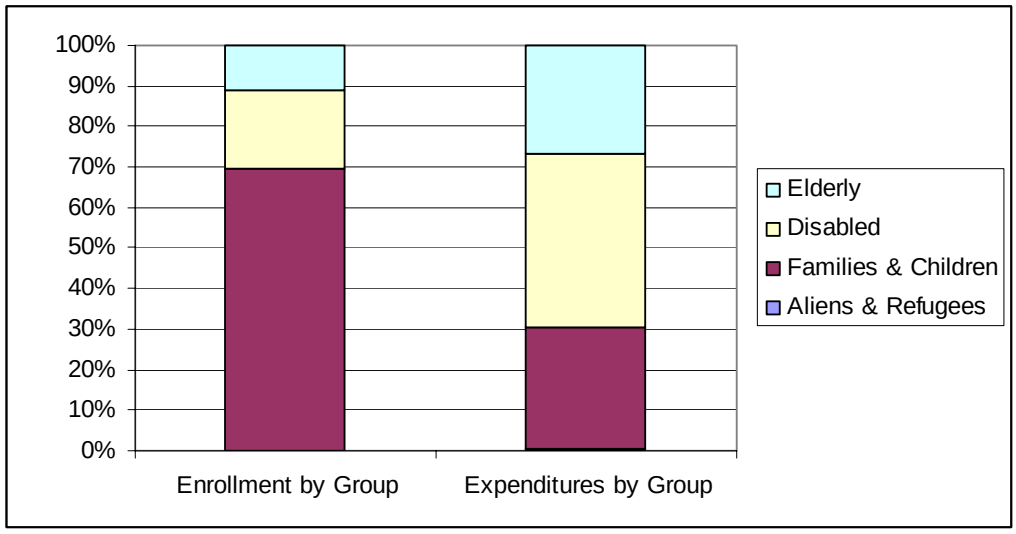
maximum payment rate for SA is based on the maximum rate an adult care home can charge for room and board (in 2005 it was $1,084 per month). SA is available to applicants with total countable monthly incomes of $1,129.50 or less and resources of $2,000 or less. The SA program sends checks to beneficiaries based on the individual's monthly income and the maximum rate an adult care home can charge (which in 2005 is $1,084 per month).

The State/County Special Assistance In Home program provides a supplement to individuals to allow them to pay for a variety of supports necessary to remain home, including housing and food costs and services, such as in-home aides. To qualify for the SA In-Home Program, the applicant must be eligible for Medicaid for the Aged, Blind and Disabled as categorically needy. However, eligibility for Medicaid for SA/IH recipients is not automatic as it is for SA in adult care homes. Recipients in private living arrangements must be determined eligible for Medicaid separately. Until recently, the in-home state and county special assistance program was limited to 800 slots at half the reimbursement rate of Adult Care Homes. As of October 2005, the General Assembly increased the available slots to 1,000 and the payment to 75 percent of the Adult Care Home Reimbursement Rate, or $873 per month (the maximum rate for adult care homes was increased from $1,084 to $1,118 per month effective October 1, 2005).

2. Population and Enrollment Trends

While older adults and persons with disabilities comprised only 30.2 percent of the Medicaid enrolled population in SFY2005, they accounted for 69.6 percent of the state's Medicaid expenditures (see ***Figure 1***).[17]

Figure 1: Distribution of Enrollment and Spending by Enrollment Group, SFY2005

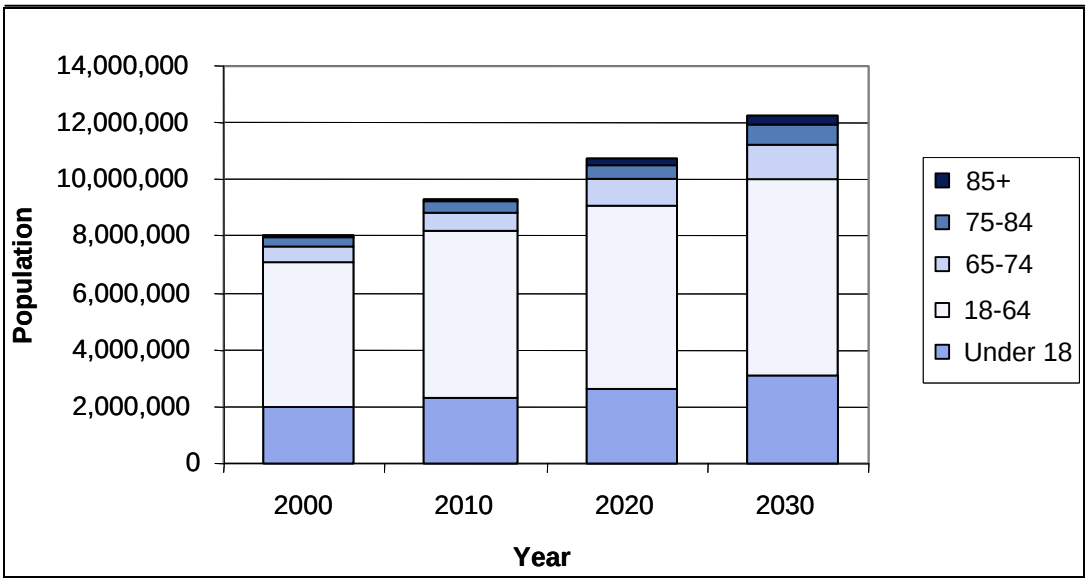


Source: Unpublished Medicaid data for State Fiscal Year 2005 provided by the North Carolina Division of Medical Assistance, November 2005.

[17] Unpublished Medicaid data for State Fiscal Year 2005 provided by the North Carolina Division of Medical Assistance, November 2005.

Projections indicate North Carolina's population will grow 16 percent between 2000 and 2010. The oldest cohort (those 85 years and older) will expand by 39 percent constituting the fastest growing group. Projected increases in the number and proportion of elderly people are due to medical advances, healthier lifestyles, increases in longevity, and, after 2010, the aging of the baby boom population. ***Figure 2*** provides the projected population growth through 2030 for different age cohorts.

Figure 2. North Carolina Projected Population Growth, 2000-2030



Source: U.S. Census Bureau, Population Division, Interim State Population Projects, 2005, Release Date: April 21, 2005.

3. Spending and Delivery Trends

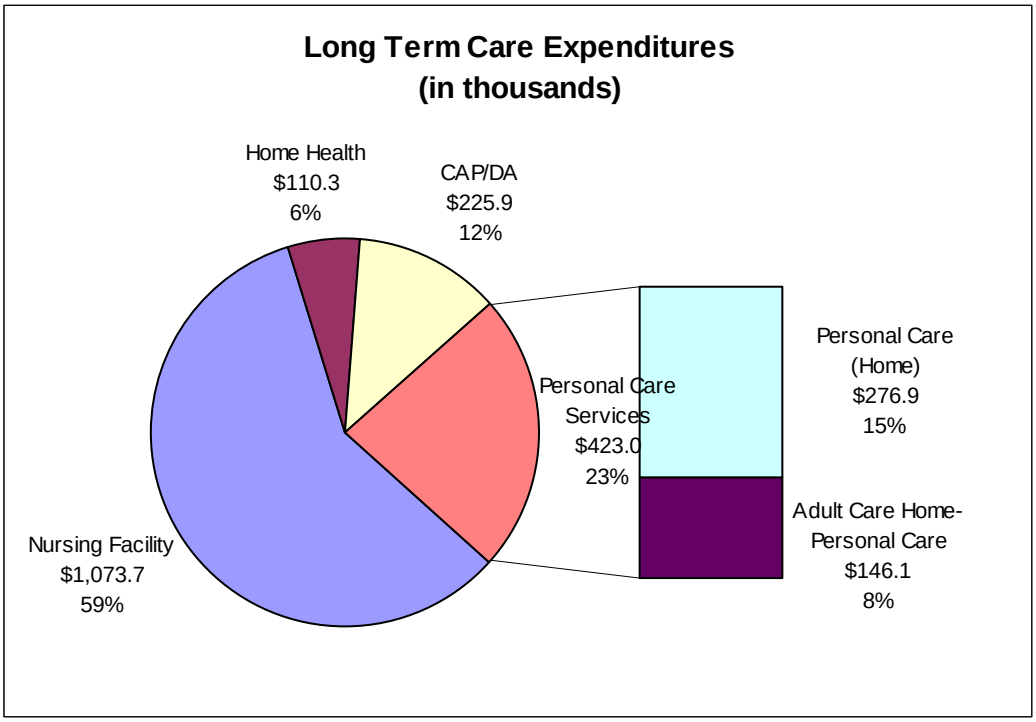
In SFY2005, North Carolina Medicaid spent $1.8 billion on LTC services for older adults and people with physical disabilities, out of a total Medicaid budget of $8.1 billion. In 2005, nursing facility outlays constituted 13.3 percent of the state's total Medicaid service dollars and 59 percent of the state's total Medicaid LTC spending considered in this report for older adults and people with physical disabilities, while nursing facility residents made up 27 percent of LTC recipients in the same year (***Figure 3***).[18] North Carolina's 59 percent of Medicaid LTC spending for nursing facility care compares to a national average of 75 percent in Federal Fiscal Year 2004, placing North Carolina in the top 10 states with the lowest proportion of Medicaid LTC spending for nursing facility care.[19]

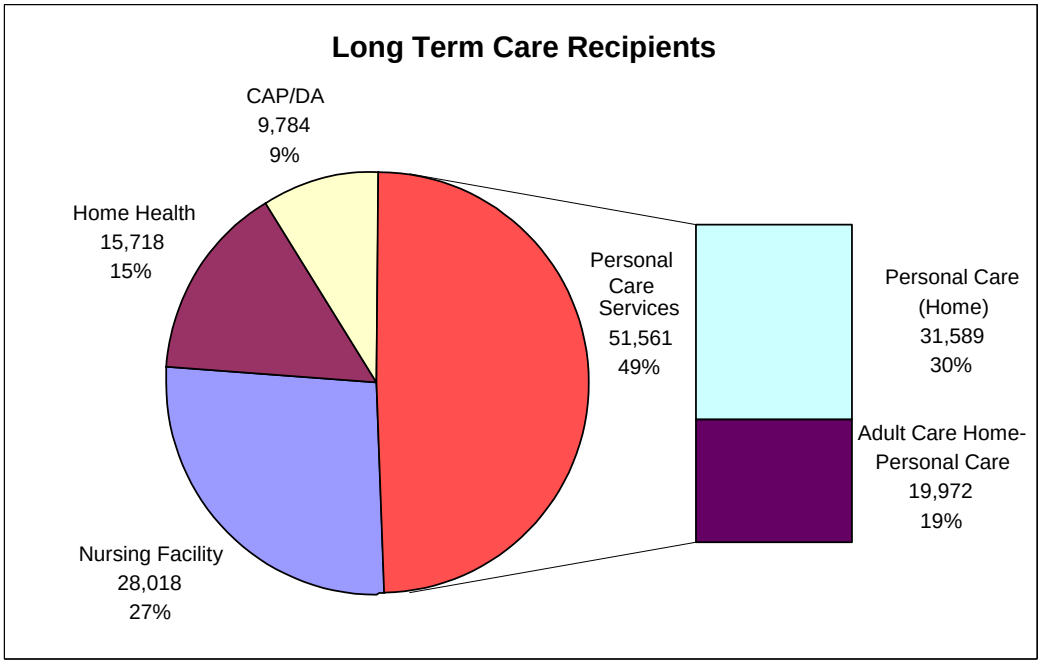
In North Carolina, Personal Care Services account for the majority of the Medicaid home and community-based services spending and three-quarters of all recipients. In fact, personal care service recipients represent almost one-half of total Medicaid long term care users among older adults and people with disabilities.

[18] Unpublished Medicaid data for State Fiscal Year 2005 provided by the North Carolina Division of Medical Assistance, November 2005.

[19] Burwell, Brian. MEDSTAT, Inc. *Medicaid Long-Term Care Spending Trends 2004*. Accessed at www.hcbs.org on May 23, 2005.

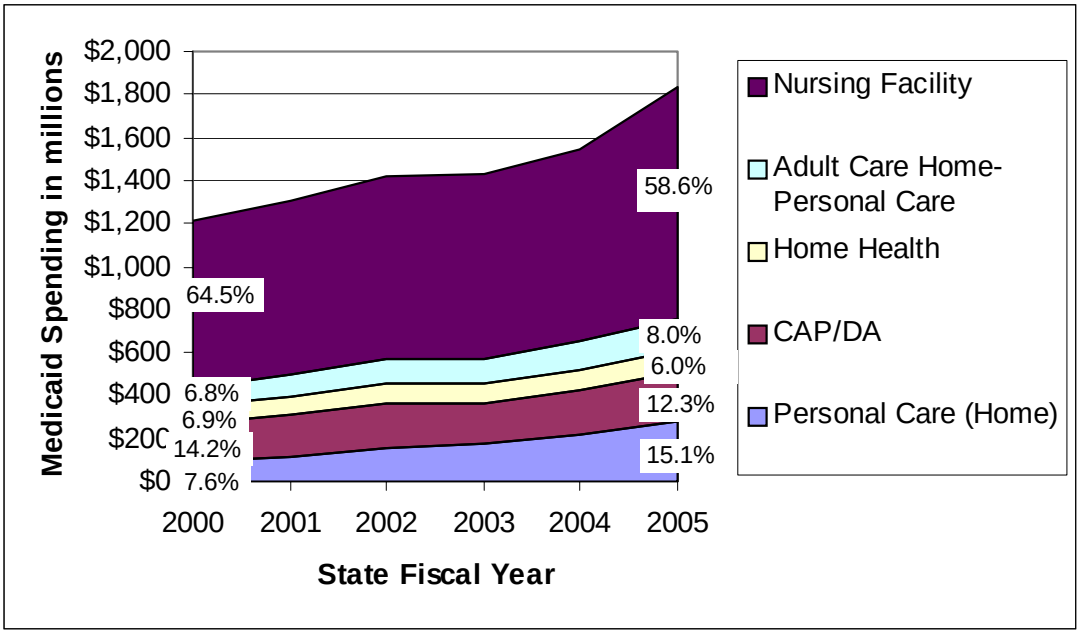
Figure 3. North Carolina Medicaid LTC Expenditures and Recipients for Older Adults and People with Physical Disabilities, 2005

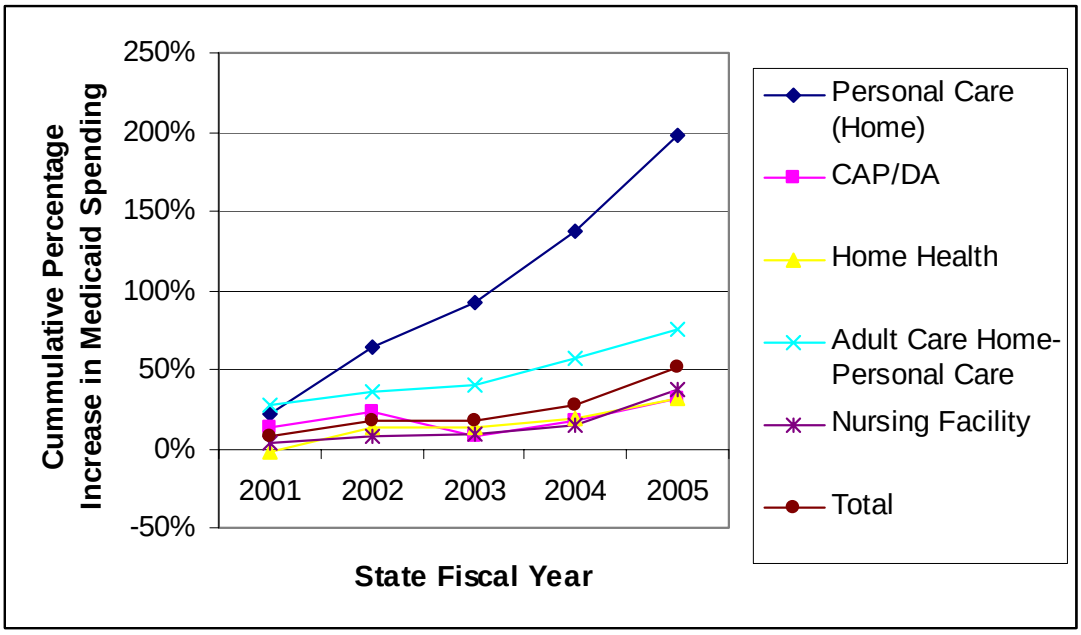




Source: Unpublished Medicaid data for State Fiscal Year 2005 provided by the North Carolina Division of Medical Assistance, November 2005.

Figure 4. Growth in North Carolina Medicaid LTC Expenditures, 2000-2005





Source: Unpublished Medicaid data provided by the North Carolina Division of Medical Assistance, November 2005.

As shown in ***Figure 4,*** expenditures for both nursing facilities and HCBS have steadily increased in the past five years, with Medicaid HCBS growing from 35.5 to 41.4 percent of total Medicaid

long term care spending for older adults and people with physical disabilities.[20] During the last five years, most of the growth in Medicaid HCBS results from significant growth in personal care services, particularly those provided in individual's homes. PCS expenditures for those in their homes nearly tripled ($92.9 million to $276.9 million – 24.4 percent annually), while PCS spending in adult care homes rose 75.8 percent or 11.9 percent annually ($83.1 million to $146.1 million). The increase in PCS provided in people's homes corresponds with the initiation of the State/County Special Assistance (SA)/In-Home program as a demonstration in 1999 with 400 slots in 22 counties to 800 slots in 63 out of 100 counties in December 2004, although this program accounts for only a small portion of the growth.[21] In 2005, this program provided up to $798 per month to individuals living at home who require an adult care home level of care with 50 percent of the funding from the state and the other 50 percent from the county.

CAP/DA, home health, and nursing facility services grew at more modest rates (31.2, 31.9 and 36.9 percent over the last five years; 5.6 to 6.5 percent annually). The more modest growth in CAP/DA spending stems from a freeze on CAP/DA program enrollment from 2001 until August 2002. Spending for CAP/DA, however, rebounded in the past two years as a result of the legislature authorizing an expansion of the CAP/DA program in July 2004, which resulted in a 12 percent increase in spending during SFY2005.[22]

C. Ongoing Initiatives and Recent Legislation

North Carolina has also applied for and received federal funding for a number of Real Choice Systems Change grants from CMS. Among the grants received by North Carolina are:

- **Aging and Disability Resource Center** (ADRC) grant, $800,000, awarded in 2004. The ADRC grant program is intended to stimulate the development of state systems that integrate information and referral, benefits and options counseling services as well as facilitating access to publicly and privately financed LTC services and benefits.
- **Mental Health Systems Transformation** (MHST), $293,796, awarded in 2004. This grant will incorporate evidence-based practices into the mental health system by assisting Local Management Entities to develop infrastructure necessary to support the implementation of evidence-based practices within their local communities.
- **Integrating Long-Term Supports with Affordable Housing** (HOUSE), $775,124, awarded in 2004. The grant is designed to bring technical assistance to local communities to expand the collective capacity of the human service system to maximize community housing resources and promote the expansion of affordable community housing opportunities integrated with long term supports for persons with disabilities.
- **Rebalancing Initiative**, $249,500, awarded in 2004. This grant will develop a targeted Rebalancing Plan to prevent and correct inappropriate placements of adults with

[20] Unpublished Medicaid data for State Fiscal Year 2005 provided by the North Carolina Division of Medical Assistance, November 2005.

[21] North Carolina Department of Health and Human Services, Division of Aging and Adult Services, *Special Assistance In-Home Program: Final Report*, February 2005. http://www.dhhs.state.nc.us/ltc/SAInHomeFinalReport2005.pdf

[22] Unpublished Medicaid data for State Fiscal Year 2005 provided by the North Carolina Division of Medical Assistance, November 2005.

significant physical disabilities in institutions such as nursing facilities. It will test and revise the Rebalancing Plan based on formative evaluation data gathered in the pilot phase of the project.

- **Family-to-Family Health Care Information and Education Centers**, $150,000, awarded in 2004. This grant will increase the amount of information, education, and training available to assist families of children with special health care needs to meet these needs. It will also enhance the capacity of existing organizations and agencies to serve children with special health care needs and their families.

- **Direct Service Worker** grant, entitled "Caregivers are Professionals, Too (CAPT)", $1,403,000, awarded in 2003 to Pathways for the Future, Inc. This grant will provide affordable health insurance through subsidized employee premiums for all eligible direct service workers, implement a career ladder, including other continuing education and career advancement opportunities, and implement a merit-based recognition program.

- **Quality Assurance and Quality Improvement in Home and Community-Based Services**, $475,100, awarded in 2003. This grant will create a model to monitor and improve the quality of initiatives to help people transition to community settings ("transitioning populations") from psychiatric institutions, intermediate care facilities for people with mental retardation, and child residential treatment facilities. The project will also devise a plan to test this system and then expand it to all State users of long-term care.

- **Nursing Facility Transition Grant**, $600,000, awarded in 2002. This grant has been used to design and implement a program that supports transition assessment and assistance for individuals in nursing facilities who are Medicaid-eligible or who will be Medicaid-eligible within 6 months who wish to return to their communities. It will build the infrastructure and capacity to sustain the transition effort beyond the grant period for current residents of nursing facilities who have the desire and the capacity to transition with support services of their own.

- **Community-Integrated Personal Assistance Services and Supports**, $725,000, awarded in 2002. The purpose of this grant is to build community capacity and infrastructure to support consumer-directed personal assistance services and supports across populations needing long term supports, including physical and cognitive disabilities and long term illnesses. The CAP/Choice program was a result of the grant efforts.

- **Real Choice Systems Change/ Direct Care Workforce Recruitment and Retention**, $1,600,000, awarded in 2001. This grant sought to improve the size, stability, and quality of the State's direct care workforce to address the current workforce crisis, and expand this workforce to better meet the personal care and home management needs of persons with disabilities now and in the future.

This past session, the General Assembly passed a number of measures intended to improve the delivery of long term care services in North Carolina. These include greater oversight and

gatekeeping for in-home personal care services and movement toward a regional system of care management for individuals with chronic conditions.

- **Home Care Agencies**. The Medical Care Commission was authorized to adopt rules that address the staff qualifications, minimum training and education requirements, staffing levels and supervision for home care agencies, which will be inspected at least every three years.

- **Adult Care Homes.** There were a variety of changes related to services in adult care homes. First, legislation passed that created specialized care units (SCUs) for people with Alzheimer's and related diseases. In October 2006, PCS rates were increased from 1.1 hours per day to over 4 hours per day for adult care homes that have specialized SCUs - currently, 88 facilities. Second, the Division of Aging and Adult Services will develop a star rating program for adult care homes, not tied to reimbursement. DOA is also piloting a quality improvement project for adult care homes which will be implemented by county social services offices. Finally, DHHS is directed to implement annual monitoring for regulatory compliance and physical plant and life-safety inspections for licensed ACH requirements every two years by July 1, 2007.

- **Community Alternatives Program.** DMA will study a new case-mix reimbursement system for the CAP waivers. The system, when implemented, will tie payment to level of need for individual beneficiaries, as is currently used for nursing facilities and home health agencies. In the future, the State plans to implement case-mix reimbursement for all CAP programs except CAP-MR/DD.[23]

- **Personal care services.** State legislation directed DMA to cut costs for the PCS program -- $13 million in state funds in the first year and $16 million in the second year. DMA plans to identify individuals who have less than two ADLs and remove them from the program. (Currently, there is no prior approval for PCS; individuals can simply have a physician approve services.) All In-Home PCS recipients will be reviewed for clinical eligibility.

- **Community Care Networks.** Community Care Networks are non-profit organizations comprised of safety net providers, including community physicians, hospitals, health departments, and county departments of social services. CCNs are paid a small fee per member per month and manage care for enrollees. The General Assembly wants to expand the program to the aged, blind and disabled population and set aside funding for several pilot programs for this population.

- **State/ County Special Assistance (SA) In-Home.** State/ County Special Assistance provides a supplemental payment for eligible individuals to help cover their residential costs in an adult care home or to assist with the cost of maintaining the individual in their own home. In 2005, the Legislature increased the amount SA in-home recipients

[23] Enacted budget, Senate Bill 622, Session Law 2005-276, approved August 13, 2005, p. 129, available at: http://www.ncga.state.nc.us/homePage.pl.

can access from 50% to 75% of the SA payment they would receive in an adult care home. In addition, the slots for SA in-home were increased from 800 to 1,000.

III. BIAS FINDINGS AND RECOMMENDATIONS

As noted in the Introduction, the goal of this study is to determine whether an institutional bias exists in North Carolina's Medicaid-financed LTC services and, if so, what steps should be taken to ameliorate any bias. Lewin reviewed policies and related administrative practices that may generate a bias for the use of institutional services over home and community-based services. Lewin also conducted interviews with key informants such as state staff, providers, and consumers. The interviews assessed the application of policies in practice and operational implications (whether intended or not) that may also contribute to or ameliorate an institutional bias.

The review focused on four areas:

- **Medicaid long term care benefits–** the medical criteria and necessity rules and practices, and the amount, scope and duration of mandatory and optional benefits
- **Long term care availability and accessibility–** the Medicaid income and financial eligibility rules, eligibility process, and medical/functional assessment and care planning; the process for accessing long term care services, and provider capacity
- **Cost containment practices–** a variety of measures to manage costs including prior approval, spending caps, utilization management, case management, and rate setting
- **Long term care provider regulation and oversight–** the different mechanisms in place to assure quality in long term care, including facility and personnel licensing and certification, utilization management, and prior approval

It is worth noting here that Medicaid is governed by both federal and state statutes and rules, and then implemented on a state and local level. To the extent possible, we have noted whether North Carolina Medicaid LTC policy or practice results from a federal requirement, state requirement, or state/local practice. North Carolina has limited ability by itself to change federal rules and requirements. However, where the institutional bias results from state decisions and rules or from the consequences of applying state and federal rules at the state and local level, North Carolina will have correspondingly greater freedom to develop appropriate responses to limit or correct the bias.

Our overall findings are reviewed below, along with recommendations for steps the state could take to alleviate bias. In some cases, the factors that lead to bias are the result of federal policies that the state has little opportunity to change, or stem from larger health care and social system characteristics that can be influenced, but not controlled, by changes to the Medicaid program. Nonetheless, all of the possible contributors to bias identified during this study are discussed here to provide the broader context for future policy analysis and decision-making. Although Lewin identified potential biases that are affected by state and federal policies, our recommendations focus on changes that can be made at the state level to minimize institutional bias. Where possible, Lewin has noted whether the change would require legislative action.

A. Medicaid Long Term Care Benefits

The first area considered for possible institutional bias was the Medicaid benefit package, particularly LTC benefits delivered in institutions and in home and community settings. Both federal and state rules govern Medicaid benefits: the federal government specifies which mandatory benefits states must offer to Medicaid beneficiaries, as well as which optional benefits they *may* offer. Under federal law, if a state chooses to participate in Medicaid, then every eligible state resident, regardless of location within the state, becomes entitled to receive mandatory and state-adopted optional services. States have some flexibility to design and offer alternative benefit packages tailored to certain groups of beneficiaries, such as an HCBS waiver for older adults and adults with physical disabilities. All benefits must be delivered by Medicaid-certified providers.

In addition to determining which optional benefits to cover, states must also determine the "amount, scope, and duration" for all covered services. These limitations on benefits include specifying where services can be provided, how many or how much may be provided, and what criteria will be used to determine if the services are "medically necessary." For example, many states offer optional state plan personal care services, but limit the number of hours that may be used and/or where they may be delivered.[24] Any of these elements—what benefits are offered (and to whom), how they are defined, and how they are authorized and delivered across settings—may contribute to an institutional bias.

Bias #1: Federal provision to reimburse Medicare Part D prescription drug copays for nursing facility residents (Federal Policy)

The Medicare program will reimburse Part D copayments for nursing facility residents, however, CAP/DA participants who also meet the nursing facility level of care will have to pay their own copayments.

Recommendation:

Addressing this bias would require a change in federal legislation or legislation authorizing state revenue to cover the copays by the North Carolina Assembly.

As of January 1, 2006, Medicaid no longer covers prescription drugs for low-income Medicare beneficiaries because the new Medicare Part D Prescription Drug benefit began. A high percentage of long term care recipients receive both Medicare and Medicaid coverage (dual eligibles). For the dual eligibles, Medicare Part D covers the copayments for drugs included on the plan's formulary of a nursing facility resident (regardless of which tier the drug may be on), but not CAP/DA participants creating a bias in favor of nursing facility care.[25] In addition, nursing home residents are protected from being denied prescription drugs by provisions of the

[24] Summer, Laura and Emily Ihara, *The Medicaid Personal Care Services Benefit: Practices in States that Offer the Optional State Plan Benefit*, for the AARP Public Policy Institute, August 2005. http://assets.aarp.org/rgcenter/health/2005_11_medicaid.pdf

[25] The Medicare Part D benefit also resulted in some CAP/DA participants who gained eligibility as a result of medically needy spenddown to lose their CAP/DA benefit because without the prescription drug expenditures, they lacked sufficient medical expenses to meet the $242 medically needy limit.

nursing home reform law that require facilities to provide all services required by the resident's comprehensive assessment, regardless of the availability of Medicare or Medicaid payment.[26]

Aside from the federal bias in Medicare Part D prescription drug copay coverage, Lewin did not identify an institutional bias in North Carolina's Medicaid long term care offerings. Despite an inherent bias in the federal specifications regarding the entitlement of nursing facility care and the requirement of home and community-based waivers in order to offer non-medical community supports (meals and chore services) included in the nursing facility rate, the mandatory Medicaid benefits offered by North Carolina meet the basic needs of a large portion of the LTC population. For people who are Medicaid eligible, these benefits offer the array of services needed to maintain appropriate health care services both in institutions (i.e., nursing facilities) and in home and community-based settings (i.e. home health and personal care services). However, these Medicaid services do not offer additional non-medical community supports (such as respite care and chore services) for LTC beneficiaries, except under the CAP/DA waiver. North Carolina compensates for this by offering the State/County Special Assistance benefits which allows individuals to cover room and board, as well as other services not offered by the state plan personal care benefit.

North Carolina offers an array of optional services to meet the social support needs of older adults and persons with disabilities. Personal care services can be a critical long term support to allow an individual to continue to live in the community. North Carolina has chosen to provide the major optional benefits a state can choose to cover through its Medicaid State Plan, including some benefits that many other states have chosen not to cover (e.g., private duty nursing). In addition, North Carolina places few limitations on the duration of these services and has fewer prior authorization restrictions than many other states and payers, such as Medicare.[27] North Carolina has also overcome the nursing facility entitlement bias by offering the State/County Special Assistance program for both adult care homes and in home to assist with the room and board, as well as non-personal care needs of individuals with disabilities.

In comparison to the other states examined as part of this study, North Carolina offers relatively generous personal care services benefits. The proportion of 2004 Medicaid long term care spending for home and community-based care (including those with mental retardation) was 38.8 percent in North Carolina, while it was 26.0 percent in Florida, 24.8 percent in Georgia and 43.4 percent in New York.[28] While Florida, Georgia, and New York offer personal care through home and community-based waivers, only New York and North Carolina offer this service as a State Plan option for all Medicaid long term care beneficiaries, including those not enrolled in waivers. Georgia does not offer PCS outside the waivers. Florida has a limited PCS program for persons residing in alternative residential settings. Not all of the states offer personal care in an individual's own residence. Florida does not reimburse for PCS in a beneficiary's home. In

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[26] Patricia B. Nemore, *Medicare Part D: Issues for Dual Eligibles on the Eve of Implementation*, for the Henry J. Kaiser Family Foundation, November 2005. http://www.kff.org/medicare/upload/Medicare-Part-D-Issues-for-Dual-Eligibles-on-the-Eve-of-Implementation-Issue-Brief.pdf

[27] Milligan, Chuck, Merritt, Kristi, Forbes, Moira, and Lo, Jonathan. *North Carolina Medicaid Benefit Study*. The Lewin Group, May 1, 2001.

[28] Burwell, Brian. MEDSTAT, Inc. *Medicaid Long-Term Care Spending Trends 2004*. The national average for 2004 Medicaid home and community based care as a percent of Medicaid long term care spending was 35.5 percent. The highest percentage was in Oregon at 70.5 percent and the lowest in Mississippi at 5.2 percent.

Georgia, personal support services may be offered at home if the provider is licensed as a "Private Home Care Provider."[29] Similar to North Carolina's PCS and PCS-Plus, New York's reimburses for three levels of PCS to meet the needs of individuals with varying needs. Like all other states, North Carolina also offers personal care and other supports through its home and community-based waiver, CAP/DA.

B. Long Term Care Availability and Accessibility

1. Accessing Long Term Care

In North Carolina, there are multiple points of entry into HCBS waiver programs and Medicaid State Plan services. While the 100 county Departments of Social Services (DSS) process financial eligibility applications, as will be discussed in greater detail in the following sections, medical/functional eligibility determinations for Medicaid long term care benefits can be completed by any physician in the state. To the extent possible, county DSS staff work closely with hospitals to identify individuals who are being discharged and assisting them to set up support services in the community. However, tight staffing levels in the counties limit these efforts.

In October 2005, North Carolina completed work on a new simplified Adult Mail-In Medicaid application (AMIM) for community based long term care services. The application form, which is available on-line, can be downloaded, completed and mailed to the county DSS office or lead agency. The application is approximately 10 pages in length, plus instructions.[30] The availability of this application should improve the accessibility of long term care services, however, one limitation of the application is that it is not used to determine eligibility for the Special Assistance program.

In addition to financial eligibility, individuals are screened medically to ensure that they require services at the nursing home level of care. The screening process is used to determine if an individual meets the medical and functional criteria for LTC before qualifying for these services, and to identify the most appropriate services for their needs. The medical/functional screen generally assesses an individual's ability to conduct "activities of daily living" (ADLs), such as eating, bathing, dressing, and toileting, and "instrumental activities of daily living" (IADLs), which include personal hygiene, light housework, and medication management. During interviews with state staff, providers and consumers, Lewin staff did not hear any comments or complaints about the timeliness of conducting medical/functional assessments, suggesting that this is not a barrier to community care.

Both nursing facility services and the CAP waivers require that individuals need nursing facility level of care services. Some home and community-based services, such as personal care services and hospice, are available to all Medicaid beneficiaries who meet the clinical criteria or demonstrate medical necessity and do not require a separate medical/functional assessment as part of the eligibility process. Currently, physician recommendation is required for both the medical screening of level of care and service authorization for state plan LTC services.

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[29] Georgia Department of Community Health, *Policies and Procedures for Personal Support Services*, Revised October 1, 2005.

[30] The application can be found at: http://info.dhhs.state.nc.us/olm/forms/dma/dma-5000.pdf.

Bias #2: Lack of simplified access and consistent support coordination system (State Administration/ Local Operation)

The lack of simplified access and consistent service coordination systems across Medicaid services makes it more difficult to coordinate the range of LTC services and supports in the community than in an institution.

Recommendation:

Study ways to improve efficiency and effectiveness of the eligibility process and case management.

Simplified access and greater coordination of home and community-based services would benefit individuals with chronic illnesses and disabilities in the community and their families. With the exception of the two Aging and Disability Resource Center (ADRC) pilot sites in Forsyth and Surry counties, North Carolina lacks a streamlined and coordinated system for obtaining information for making decisions about long term care and accessing services.

For state plan personal care services, no entity currently coordinates the financial and medical/functional eligibility process either in Adult Care Homes or for In Home PCS. However, North Carolina recently embarked on an initiative for greater centralization of access to In Home PCS through review of the eligibility. For the CAP/DA program, North Carolina has 96 lead agencies that provide information to consumers about community-based LTC options. The large number of varied agencies contributes to inconsistency in the process. Lack of central management makes it difficult for DMA to communicate with lead agencies, collect information and data about their activities, and identify program trends. On the other hand, nursing home residents benefit from facility staff who coordinate and complete all the necessary paperwork for Medicaid benefits based on the facility's self interest to receive Medicaid payments.

It should be noted that the other states examined as part of this study also struggle with simplifying the access process for long term care. Similar to North Carolina, both Florida and Georgia are pursuing the ADRC model in pilot sites, but currently lack state-wide, robust single-point-of-entry systems. The comparison states for this study are also struggling to simplify the eligibility process and to better coordinate the financial eligibility and medical/functional assessment processes. In Florida, the state plans to co-locate financial and medical/functional eligibility either physically or virtually. Georgia plans to co-locate Medicaid eligibility specialists (who conduct the financial eligibility process) at local ADRCs to assist individuals with the application process. Both Florida and Georgia have plans for developing consistent, statewide systems. Florida's legislature authorized statewide Aging Resource Centers. Georgia is the process of developing a single point of entry program that will be built off of their "Gateway" system. Gateway is a computerized screening tool that helps to link consumers with available services. The tool, which has been tested for reliability, predicts whether an individual will be eligible for services and helps identify providers in his or her county.

North Carolina could improve outreach about Medicaid and other social services programs. Although there is a toll-free number for information and assistance, it does not appear to be

well advertised. North Carolina should consider implementing a single point of entry approach for LTC services in the state. North Carolina can build upon the activities and lessons of the federal Aging and Disability Resource Center grant. At the least, North Carolina should consider organizing the lead agencies and county DSS by region, so that DMA can work with regional coordinators to disseminate information to and get information from these entities. DMA should also resurrect lead agency staff training programs (e.g., about the CAP waivers and the benefits allowed under each waiver). DMA could also develop written materials for use by the lead agencies and county DSS. DMA may also consider working closely with the State Health Insurance Information Program (SHIIP) to improve outreach about community-based services options.

While services coordination or case management can assist beneficiaries in accessing services, maximizing beneficiary independence, reducing fragmentation of care, and managing costs, it lacks consistency in North Carolina. In nursing facilities, all services are literally provided "under one roof." The range of providers (e.g. physician, nurses, nurse aides, dieticians) can communicate easily about a person's care plan and health status. However, in home and community-based settings, providers for different services are often employed by different agencies and greater effort is needed to ensure that they coordinate appropriately. All CAP/DA waiver participants receive case management through the Lead Agencies, but only an average of one hour per month and this varies by Lead Agency. Only Adult Care Home PCS residents who qualify as enhanced care residents (17 percent of ACH-PCS recipients in SFY2005) receive Medicaid funded Adult Care Home Case Management services and Special Assistance/In Home participants (two percent of IH-PCS recipients in February 2005) receive the Medicaid At Risk Case Management program, both provided by county DSS staff. Also, in contrast to ACH-PCS and CAP/DA case management, counties must pay the full Medicaid match for At Risk Case Management provided to SA/In Home recipients (63.63% federal Medicaid dollars and 36.37% county dollars). At times, this impacts county DSS' ability to fill the SA/In-Home slots timely due to limited staffing resources. [31] North Carolina hopes to address these disparities in part through the emerging Community Care Networks. Also, the CAP/Choice HCBS waiver being piloted in two counties allows individuals to coordinate their own care (but is currently limited to a small number of participants).

Among the comparison states, Florida is seeking to improve its care coordination process through a new comprehensive waiver that would use a managed long term care model, Florida Senior Care, for adults over age 60 and a separate program for individuals with physical disabilities. Several other states have used managed care models to help coordinate care for their LTC waiver enrollees, including Arizona, Minnesota, New York, and Wisconsin. In the past Vermont applied managed care elements to its fee-for-service delivery systems, but recently received approval for a comprehensive 1115 waiver for long term care services.

North Carolina should consider implementing strategies to improve the efficiency and effectiveness of the existing case managers, which may include some strategies tested in managed LTC models. The state should also consider reducing case manager to beneficiary ratios. Specifically, the state should convene periodic face-to-face meetings for case managers to

[31] North Carolina Department of Health and Human Services, Division of Aging and Adult Services, Special Assistance In-Home Program: Final Report, February 2005. http://www.dhhs.state.nc.us/ltc/SAInHomeFinalReport2005.pdf

learn about activities in other counties and provide a forum for training and education. These meetings could highlight changes in state policies, allow for consistent information to be shared with agency staff, and would assist in building bridges between and among the different organizations responsible.

2. Eligibility for Long Term Care

Medicaid LTC program and service eligibility rules and processes were also examined to determine whether there is an institutional bias. LTC services require a formal clinical component as part of the eligibility process; that is, in addition to determining whether an individual meets the financial (e.g., income, assets) and categorical (e.g., age, disability) requirements of eligibility, the person must also be assessed on a functional and clinical basis. As with Medicaid benefits, Medicaid eligibility rules generally have both a federal and state component. Certain groups of individuals must be covered (mandatory groups), while states can choose whether to cover others (optional groups). In addition, within most eligibility groups, states can determine how income and assets are counted and how other eligibility criteria are met. The rules and processes for how persons become eligible for Medicaid and how they are assessed for LTC may contribute to an institutional bias if they make it easier for an individual to be eligible for institutional care than home and community-based services.

a) Medical/Functional Eligibility

No Bias Found: Medical/Functional Eligibility for Medicaid Long Term Care Services (State Administration)

While level of care appropriately differs for the alternative settings, all require physician approval to receive services.

Lewin did not identify an institutional bias related to medical/functional eligibility criteria or processes.

A physician must certify that individuals meet the nursing facility level of care to become eligible for either nursing facility or CAP/DA services, while adult care home residents must meet ACH level of care for ACH-PCS. ***Table 1*** shows that for nursing facility, CAP/DA, ACH-PCS and nursing facilities, the FL-2 form must be signed by a physician to authorize services. In November 2005, a new process has been put in place for In Home PCS that involves prior authorization by a third party that applicants meet the two unmet activities of daily living (ADLs) and a chronic medical condition. For home health, private duty nursing, and hospice services, physician approval is also necessary but may occur on a per-service basis. Although bias could be introduced as a result of the lack of clear criteria and consistent application by physicians, there was no evidence that physicians steer individuals to one setting over another. As a result, while the forms differ somewhat, the processes are fairly similar and do not appear to bias nursing facility care relative to home and community-based services.

Table 1. Services and Required Forms/Assessments

	Nursing Facility	Adult Care Home	PCS-In Home	CAP/DA
PASARR	X			
Level of Care	NF LOC	ACH LOC	2+ unmet ADLs & chronic medical condition	NF LOC
Physician Approval	FL-2	FL-2	DMA-3000 Physician Authorization for Certification of Treatment (PACT)	FL-2
Assessment Form	Nursing Facility Minimum Data Set (MDS)	DMA-3050R, Resident Register, and Enhanced Care Assessment Form		Automated Quality and Utilization Improvement Program (AQUIP) data set

b) Financial Eligibility

Individuals generally qualify for Medicaid through one of four eligibility paths: 1) Supplemental Security Income-linked eligibility; 2) categorically needy eligibility; 3) medically needy eligibility; or 4) State/County Special Assistance for Adult Care Homes. Married nursing facility residents and CAP/DA participants also receive spousal impoverishment protections (explained in detail under ***Bias #4***).

In North Carolina, people eligible for the federal Supplemental Security Income (SSI) program are automatically Medicaid eligible.[32] In 2005, to qualify for SSI, an individual must be disabled according to the Social Security Administration (SSA) definition and have income equal to or less than $579 per month or $896 per month for a couple, and have no more than $2,000 in resources for an individual or $3,000 for a couple.

If an individual does not qualify for SSI, there are other ways to qualify for Medicaid. Persons with income above the SSI limit but below 100 percent of the federal poverty level (FPL), which in 2005 equals $798 per month for an individual, can qualify for Medicaid through the optional categorically needy aged, blind and disabled eligibility category.[33] These individuals must meet the financial limits and be determined to have a disability by North Carolina Disability Determination Services.

For persons with incomes above 100 percent of the FPL who have significant medical expenses, North Carolina has chosen to offer the optional medically needy program. This program allows persons to deduct medical expenses from their income to achieve the allowable Medicaid income limit. If the net amount is less than the "medically needy limit" (MNIL), the person may become eligible for Medicaid. The medically needy limit in North Carolina is $242 per month

[32] North Carolina Medicaid State Plan, Attachment 2.6-A, available at: http://www.dhhs.state.nc.us/dma/sp.htm. To receive SSI benefits, a person must be over age 65, blind or disabled, and have limited income and resources.

[33] North Carolina Medicaid State Plan, Attachment 2.6-A, available at: http://www.dhhs.state.nc.us/dma/sp.htm.

for individuals and $317 per month for couples and the resource standard is $2,000 for individuals and $3,000 for couples.

The difference between the person's income and the medically needy income limit is their medical deductible. Exhibit 1 below shows an example of how an individual with an income of $850/month would qualify through the medically needy option with monthly medical expenses of $550 or $650.

Exhibit 1. Medically Needy Eligibility Calculation Example

$850	Monthly Income	$850	Monthly Income
- $550	Medical Expenses/Deductible	- $650	Medical Expenses/Deductible
= $300	Income to Compare to MNIL	= $200	Income to Compare to MNIL
$242	Medically Needy Income Limit	$242	Medically Needy Income Limit
$300 > $242, person *would not* qualify		$200 < $242, person *would* qualify	

This deductible can be met with certain unpaid medical bills and current medical expenses. North Carolina determines eligibility for Medicaid through the medically needy program for a six-month period for all beneficiaries except CAP enrollees. There are two special rules for medically needy CAP beneficiaries. The deductible for CAP is calculated on a one-month rather than a six-month basis, as used for medically needy State Plan beneficiaries. This is the same approach used for nursing facilities.

Special Assistance for Adult Care Home residents is available to applicants with total countable monthly incomes of $1,129.50 or less and resources of $2,000 or less. Once approved for SA-ACH, these residents automatically qualify for Medicaid. The SA program sends checks to beneficiaries based on the individual's monthly income and the maximum rate an adult care home can charge (which in 2005 is $1,084 per month). For example, if a person's monthly income is $800, SA would pay $330 towards the cost of the adult care home. The individual is allowed a personal needs allowance of $46.[34] ***Exhibit 2*** depicts two examples of SA eligibility. The first example is for a person with an income of $800/month; the second is a person with $579/month, the SSI income limit. The amount the state/county pays depends on the individual's income. Spousal protection does not apply to adult care homes.

[34] State/County Special Assistance for Adults Manual. SA-3210 Income. Available at: http://info.dhhs.state.nc.us/olm/manuals/doa/sa/man/index.htm

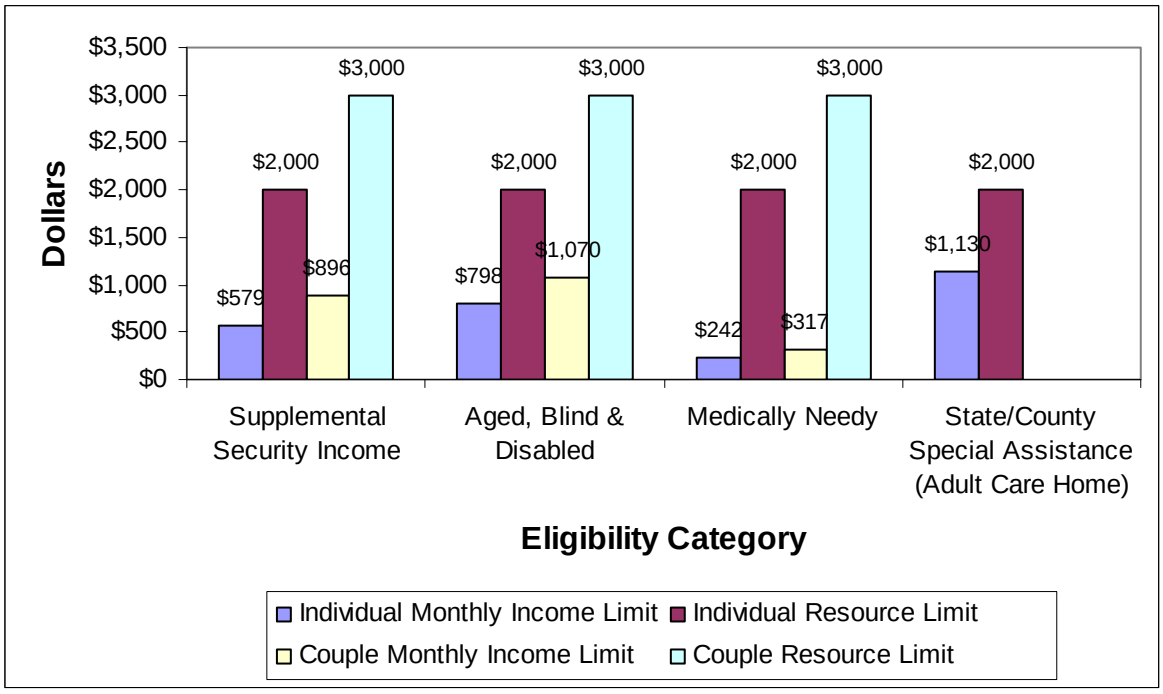
Exhibit 2. Two Examples of Eligibility and Special Assistance Payments

Example 1: Income of $800 per month		Example 2: SSI only, income of $579 per month	
$1,118	Maximum Rate (eff. 10/05)	$1,118	Maximum Rate (eff. 10/05)
+ 46	Personal Needs Allowance	+ 46	Personal Needs Allowance
= 1,164	Maintenance Amount	= 1,164	Maintenance Amount
- 800	Total countable monthly income	- 559	Total countable monthly income ($579-$20 disregard)
= $364	SA Payment Amount	= $605	SA Payment Amount

It is worth noting that to qualify for the SA In-Home Program, an applicant must be eligible for Medicaid for the Aged, Blind and Disabled as categorically needy (a lower income standard than adult care homes). Also, unlike SA in adult care homes eligibility for Medicaid among SA/IH recipients is not automatic. Recipients in private living arrangements must be determined eligible for Medicaid separately. This presents a bias between eligibility for adult care homes and individuals remaining in their homes, but both are community settings.

Figure 5 displays the key long term care eligibility categories, with their income and resource limits, in North Carolina.

Figure 5. North Carolina Medicaid Financial Eligibility Levels for Individuals and Couples, 2005



Bias #3: Medical needy requirements inconsistent across settings (State Policy)

Medically needy requirements leave little money for persons to pay for living expenses if they prefer to remain in the community, while institutions provide room and board.

Recommendation:

Increase medically needy income standard from the current monthly standard of $242 to a level at least comparable to the national average SSI ($416 for a single individual).[35] This would require the General Assembly to pass legislation to amend the Medicaid State Plan and appropriation additional funds to cover the increased Medicaid costs.

North Carolina's medically needy requirements, which require beneficiaries to "spend down" to a low level of income, contribute to an institutional bias. Individuals residing in institutions can count the full cost of nursing facility care toward their spenddown amount, while persons living in the community can count only the cost of health care and social supports (not room and board). After a North Carolina resident becomes eligible for Medicaid through the medically needy provision, he or she has $242/month to spend on housing, food, and other expenses. This allowance is likely to be insufficient to support a person living in the community.[36]

Thirty-one states have a medically needy eligibility group for the aged, blind, and disabled; of those 31 states, 24 have higher medically needy income standards than North Carolina. The average medically needy income level in the country is $416.20.[37] Of the comparison states, Florida and New York also have medically needy groups, with income standards of $180 and $642 respectively.[38] Georgia does not have a medically needy eligibility category. North Carolina should consider increasing its medically needy income standard from the current monthly standard of $242 to a level at least comparable to the national medically needy average ($414 for single individual). A higher medically needy limit would assist individuals who wish to stay in their home to more realistically be able to maintain a household by allowing for more resources available for housing costs and food.

[35] Data derived from: National Association of State Medicaid Directors. Aged, Blind, and Disabled Medicaid Eligibility Survey. Available at: http://www.nasmd.org/eligibility/. Data provided in ***Appendix C***.

[36] Nursing facility residents that wish to maintain a household also retain $242 /month during the first six months of their stay.

[37] Ibid.

[38] Ibid.

Bias #4: Spousal impoverishment provisions inconsistent across settings (State Policy)

Differences in spousal impoverishment rules can create hardships for families if a spouse prefers home or community-based care over institutional care.

Recommendation:

Align spousal impoverishment rules for LTC beneficiaries in all settings. This would require the General Assembly to pass legislation to amend the Medicaid State Plan and appropriate additional funds to cover the increased Medicaid costs.

North Carolina's spousal protection rules can be used when a legally married individual needs Medicaid's help with the cost of institutional care or qualifies for CAP/DA. The spousal protection rule helps to protect a home-residing spouse from the cost burden of maintaining two residences, while the other spouse is in a nursing facility with his/her income applied to the cost of nursing facility care. Spousal impoverishment protection includes provisions for both financial resources and income. Married CAP/DA recipients and nursing facility residents' financial resources are treated the same, while spouses of nursing facility residents are afforded an income allowance to maintain the home not available to CAP/DA participants.

In terms of resources, the community spouse is allowed to keep the greater of $19,020 or one half of the couple's assets up to $95,100. Home sites are excluded from the division of assets; the community spouse of a nursing facility resident retains the home. The spouse entering a nursing facility must spend his or her share of the combined assets, less $2,000 on care prior to becoming Medicaid eligible.[39]

The community spouse of a nursing facility resident is given an allowance if his or her income is less than 150% of the poverty level ($1,070 per month in 2005 or $14,364 annually). In some circumstances, the community spouse may also get additional income for excessive shelter costs. For CAP/DA, the service recipient is evaluated based on SSI, aged blind and disabled categorically needy or medically needy eligibility based on their own income without consideration for the maintenance of the home. ***Exhibit 3*** demonstrates the application of the income and asset provisions in a nursing facility and for the CAP program for the same married couple.

[39] Adult Medicaid Manual MA-2231: Community Spouse Resource Protection.

Exhibit 3. Example of North Carolina Spousal Impoverishment Rules

John and Ann are married. John's income is $850/month and Ann's is $400/month. They have $50,000 in joint non-housing assets.

Nursing Facility Scenario: John chooses to enter a nursing facility and therefore spousal income and resource protection rules apply. Ann may receive up to $820/month of John's income ($30 of John's income goes to his nursing facility personal needs allowance) as an income allowance if she chooses to, plus her $400/month income. Ann now has $1,220/month to live in the community. She also retains $25,000 of their joint non-housing assets (John must spend all but $2,000 of his $25,000 share.

CAP Scenario: John has decided to enroll in the CAP program. The CAP program does not consider the income of the couple, but rather the income of each individual. For John to be eligible he has to spend down to $242/month. Ann is categorically eligible for Medicaid because her income is $400. The couple now has $642/month to live in their home and retain $27,000 of their joint non-housing assets.

Note: If the roles were reversed, with the lower income spouse seeking nursing facility or CAP/DA services, the nursing facility scenario would result in the same amount for the community spouse, while under the CAP scenario, Ann would qualify based on categorical eligibility and the couple could retain their full income of $1,250.

The problem is further exacerbated for persons residing in the community who are receiving State Plan optional services, but do not have access to the CAP program. These married couples do not even receive the asset protection provided to the CAP/DA and nursing facility users. However, both CAP/DA and State Plan Medicaid participants are likely eligible for other public assistance benefits, such as food stamps and heating assistance.

North Carolina's spousal impoverishment rules create a bias towards institutional care because they are not applied equally to people entering nursing facilities and to the CAP program. The spouse of a person residing in an institution can continue to receive substantial portions of their spouse's income, which may allow the spouse to remain in the community. However, for spouses of CAP/DA waiver participants, this protection does not apply. So, a spouse is required to live on a lower income because a higher amount of the family's income is contributed to health care expenses. North Carolina should consider changing its spousal impoverishment rules for beneficiaries in HCBS settings to mirror those for individuals in institutions.

3. Provider Capacity

Key informants reported few problems with provider capacity in the LTC system, which can be a large problem in other states. North Carolina is unique in that is has several large teaching hospitals and a large medical community. As such, there appears to be little problem in provider availability.

No Bias Found: Provider capacity appears adequate in HCBS

Significant expansions in Medicaid home and community-based services suggest an adequate community long term care workforce.

Lewin did not identify an institutional bias related to provider capacity.

In the last five years, spending for the PCS in-home program nearly tripled and PCS for residents of adult care homes also increased substantially. Even though three-quarters of states, including North Carolina, reported the direct care workforce issues as a "serious issue",[40] these increases suggest a sufficient supply of direct care workers.

North Carolina has been a leader in the effort to identify workforce gaps and has made efforts to improve working conditions for direct care workers. For example, the state conducted a series of surveys on strategies to recruit and retain workers in LTC settings. The Direct Care Workers Association of North Carolina (DWA-NC) was established in 2003 and acts as an education-based organization for direct care workers in the state. North Carolina also has a "Win-a-Step-Up" program, which uses public funds to offer monetary rewards to direct-care workers who complete training or meet retention commitments.[41] In addition, Pathways for the Future, a Center for Independent Living in Sylva, North Carolina was granted a federal project aimed at developing ways to support direct service workers to ultimately improve recruitment and retention. The North Carolina grant is specifically focused on adequate compensation, recognition, and opportunity for advancement among direct service workers.

No Bias Found: Certificate of Need program appropriately limits provider supply (State Policy)

North Carolina has implemented a strong certificate of need program to limit the number and mix of providers in the state.

Lewin did not identify an institutional bias related to certificate of need.

In addition to increasing supply of providers that can support individuals in home and community-based settings, North Carolina has a longstanding effort to limit the supply of institutional long term care providers. The CON program helps to control the supply of health care facilities, agencies and beds in the state by limiting the number of health care facilities in different regions of the state. The program is intended to balance cost, quality, and access issues and ensure that only needed services and facilities are available. North Carolina's Certificate of Need (CON) program dates back to 1974 when the federal government mandated that states make efforts to control the supply of medical care in the states. Although the federal law was repealed in 1987, North Carolina continues to have a stringent CON program that regulates

[40] The National Clearinghouse on the Direct Care Workforce and The Direct Care Workers Association of North Carolina, *Results of the 2005 National Survey of State Initiatives on the Long-Term Care Direct-Care Workforce*, September 2005, available at: http://www.directcareclearinghouse.org/download/RESULTS%20OF%20THE%202005%20NATIONAL%20SURVEY%20FINAL%2092205%20_3_.pdf

[41] Ibid.

when and where LTC providers can provide services. Florida, Georgia, and New York also have certificate of need programs in place.

There are ten categories of facilities and services for certificate of need review in North Carolina. The need determinations are revised continuously throughout the year, as facilities are certified and decertified or closed.

The following LTC facilities and providers are covered under the CON program:

- Nursing care beds
- New home health agencies or offices
- New hospice inpatient beds and new hospice residential care facility beds
- Conversion of hospital beds to nursing care
- Adult care homes and family care homes

The intent of the CON process is to ensure that there is neither oversupply (which can drive up demand) nor undersupply (which can drive up demand and costs). According to the North Carolina Department of Health and Humans Services, Division of Facility Services, there were 391 nursing facilities with 42,201 certified beds.[42] In 2005, North Carolina had somewhat fewer nursing home beds per 1,000 population age 65 and older than the national average (41.5 in NC and 46.2 nationally) and ranked number 19 among all the states. North Carolina's nursing facility average occupancy rate of 88.7 percent compares favorably to the 85.6 percent national average.[43] An occupancy rate with 11 percent excess capacity on a given day generally indicates an adequate supply of nursing home beds to be responsive to short-term demands. Also, the relatively high occupancy in nursing facilities suggests that the CON process is working well in this sector.

Several years ago, the state began to require CON for adult care and family care homes.[44] There are approximately 644 adult care homes in the state and about 657 family care homes. According to the 2005 State Medical Facilities plan, there were 40,802 licensed adult care home beds in North Carolina.[45] State staff report occupancy rates in adult care and family care homes well under nursing facilities, suggesting that there may be more homes/beds than needed.[46]

Home health agencies are also monitored through CON. As of May 2005, there were 176 licensed home health only agencies in North Carolina.[47] In the 2005 State Medical Facilities Plan, authors note an increase in demand for home health services in North Carolina between

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42 http://facility-services.state.nc.us/ accessed November 2005.

43 American Health Care Association - Health Services Research and Evaluation estimates based on CMS OSCAR Form 671: L18, L37, L38, L39 and Form 672: F78. Note that OSCAR data only reflects patients who occupy a certified bed. http://www.ahca.org/research/oscar/rpt_occupancy_20056.pdf

44 Personal Interview with Robert Fitzgerald, Director, Division of Facility Services, April 6, 2005.

45 "The 2005 State Medical Facilities Plan." North Carolina State Health Coordinating Council Medical Facilities Planning Section, Division of Facility Services, Department of Health and Human Services, effective January 1, 2005. Available at: http://facility-services.state.nc.us/plan2005/plan2005.pdf.

46 Interviews with NC DMA staff, April 2005.

47 Home Health Only Facilities Licensed by the State of North Carolina. Department of Health and Human Services – Division of Facility Services, 5/31/05.

2002 and 2003.[48] However, while the number of home health agencies can be regulated, the CON does not affect the number of staff working in each agency. Thus, there is no measure corresponding to "occupancy" or "beds" when discussing or regulating home health agencies.

Both state agency staff and providers that Lewin staff interviewed for this report noted that the system works well to ensure that the proper number of providers is available to persons needing LTC services throughout the state. Limiting supply of nursing facility beds does not contribute to an institutional bias, and, in fact, works to reduce its potential. Restricting the number of HCBS and institutional providers helps to ensure that those providers who are licensed have a viable number of people to serve in their regions of the state.

C. Cost Containment

States, including North Carolina, have taken a variety of approaches to contain costs—or at least slow the growth of entitlement benefits, such as Medicaid long term care. Some of the mechanisms used by states to limit spending have already been discussed: using financial and assessment criteria to limit the number of persons who can access LTC benefits, and defining the amount, scope, and duration of covered services in order to limit utilization. In many ways, North Carolina has been generous in setting eligibility and benefit rules in ways that reduce the potential for institutional bias. However, there are other cost containment mechanisms that affect the delivery of LTC benefits and may contribute to bias. These include limits on the state's home and community-based services (CAP) waivers, the utilization management process for long term care (both prior approval and concurrent/retrospective review), and payment rates.

1. CAP/DA Cost Containment Policies

Bias #5: Application of federal waiver cost neutrality requirement (State Administration)

North Carolina's application of federal waiver cost rules may limit benefits for people with more intense needs, making it difficult for them to stay in the home or community.

Recommendation:

Develop mechanism to allow for high cost individuals to have the opportunity to receive care in the community, possibly through exceptions to the budget cap or a new system of approval. This may require additional coordination across county/lead agencies. Implementing this change would require changing the CAP Medicaid eligibility guidelines in the CAP/DA Manual and other program instructions. This change may or may not require state legislation.

The nature of HCBS waivers allows states to control costs by managing the number of people enrolled and amount of money spent. The CAP/DA program places limits on both the number of beneficiaries served and the amount that is spent on participants. This is in contrast to

[48] "The 2005 State Medical Facilities Plan." North Carolina State Health Coordinating Council Medical Facilities Planning Section, Division of Facility Services, Department of Health and Human Services, effective January 1, 2005. Available at: http://facility-services.state.nc.us/plan2005/plan2005.pdf.

nursing facility benefits, which are an entitlement and whose benefits are not subject to budget neutral provisions.

In order to gain approval for the CAP waiver from the federal government, the state must agree to certain limitations. For example, the cost of care for persons in the waiver cannot exceed the cost that would have been incurred had those persons been placed in an institution instead of receiving home and community-based services through the waiver. These limits are calculated on an aggregate basis; the state provides estimates of the number of people who will be eligible for the waiver and the total cost it expects to incur for those persons. In its submission to CMS for FY2004-2005, North Carolina estimated that 11,502 beneficiaries would enroll in the waiver at a cost not to exceed $209,089,952.[49]

When enrolling persons in the waiver, the state must ensure that the total amount spent by waiver participants does not exceed the aggregate cap agreed to in the federal waiver. In North Carolina, the state ensures that the costs associated with persons in the waiver do not exceed the aggregate cap by setting an individual monthly cost limit for each participant. The plan of care for each waiver enrollee cannot exceed an individual cost limit. The monthly cost limit for persons who meet the intermediate level of care is $2,680 and the monthly cost limit for persons who meet the skilled level of care is $3,487, as of July 1, 2004.[50]

The individual cap on waiver services' expenditures leads to an institutional bias in North Carolina. Although federal rules indicate that HCBS waivers must not exceed an aggregate expenditures level, North Carolina imposes an individual cap as part of the state's management approach to meet the waiver's federal cost neutrality requirement. Under this requirement, a waiver participant cannot spend more in the community than the average cost in a nursing facility. This means that persons with the most intense needs (i.e., those that cost more than average) may be excluded from community-based services.

North Carolina Medicaid should consider allowing individuals of all acuity levels to be served by the waiver in integrated settings. While the total cost of waiver participants may not exceed the total cost of serving similarly situated individuals in nursing facilities, additional higher-cost individuals living in the community could be balanced by others with lower expenses, keeping NC below the overall expenditure limit.

As noted above, DMA could examine and grant exceptions on a case-by-case basis by using defined criteria. DMA could also better integrate plan-of-care and cost data from the different lead agencies to ensure that aggregate costs are being kept below the program caps, while allowing additional flexibility at the local level to exceed the individual caps.

The state would have to develop clear criteria for making exceptions on a case by case basis for certain individuals with high health care and support needs, but who wish to live in the

[49] CAP/DA approval letter from Hugh Webster, Acting Associate Regional Administrator, CMS, to Gary Fuquay, Acting Director, North Carolina Department of Health and Human Services, November 26, 2003.

[50] Memo to CAP/DA Supervisors and Case Managers from Lynne Perrin, Section Chief, Facility and Community Care Services, North Carolina Division of Medical Assistance. Re: CAP/DA Monthly Cost Limit Increase. October 13, 2004.

community. Exceptions could be based on diagnosis, an assessment of unpaid supports, or other criteria. Alternatively, a system for setting budget amounts could be adopted.

DMA notes that this and other options to improve the effectiveness of the CAP/DA program and ensure that the neediest individuals are served by the program are under active consideration by the Facility and Community Care Section of DMA. Several issues are relevant to implementing this change. The Division would need:

- More and better data to estimate the costs associated with serving individuals in the CAP/DA program with higher acuity levels and to assure compliance with the federal cost neutrality requirements cited above;
- To implement a more rigorous assessment for CAP/DA participation and assess all individuals before being placed on a waiting list; and
- To wait until the new Medicaid Management Information System (MMIS) is implemented and tested before changes in reimbursement could be implemented.

The Facility and Community Care Section is currently developing a uniform screening program and automated program intake system that will address many of these issues and make these types of program changes administratively manageable.[51]

A change in the way the state meets these federal requirements would require a waiver amendment, or a change in the waiver renewal application and approval from CMS.

Bias #6: CAP/DA enrollment caps (State Policy)

Enrollment caps limit the number of people who can access care in the community.

Recommendations:

Monitor the use of newly available slots and provide funding for CAP/DA as needed. State legislation would be required for additional funding/slots. In addition, CMS must approve any increase in the number of slots.

While the nursing facility benefit is an entitlement, enrollment in a CAP waiver is not—the state can (and does) limit the number of people who can enroll. The limitation is based on the total budget available; the North Carolina budget for FY2004-2005 for the CAP/DA program is $245,841,214, which allowed for 13,200 slots (given the state's estimates of average cost per person). As an entitlement, anyone seeking nursing facility services that meets the eligibility criteria gains coverage. In contrast, the state can choose how much funding to allocate to the waiver and limit enrollment based on the amount that it has budgeted for the program.

North Carolina does impose some limits on the availability of nursing facility care through its certificate of need (CON) policy. However, the state limits the number of people who can enroll in CAP, while any financially and medically/functionally eligible person can receive Medicaid payment for nursing facility services at any time.

[51] DMA memo dated February 9, 2006 from Mark T. Benton to Theresa Matula.

The state should consider options that would allow DHHS to change the number of waiver slots available according to demand without going back to the legislature for additional budget authority. Several states have taken a holistic or incremental approach to funding. For example, Oregon and Washington created consolidated budgets for LTC spending. Texas allows Medicaid nursing facility residents who wish to transition to the community to move immediately by transferring funds from the nursing facility budget to the HCBS budget to fund their care.[52] Wisconsin has a capitated system for its Family Care that also operates this way.

Bias #7: No triage of CAP/DA wait list (State Administration/Local Operation)

There is no differentiation of need on the CAP/DA wait list.

Recommendation:

Create a priority list for waiver admission for persons at risk of institutionalization. This could require state legislation to appropriate additional funds to cover the activities to prioritize the wait lists. However, better targeting of individuals who might otherwise be institutionalized could save nursing facility costs.

States have many options to manage how a person obtains access into waiver programs. In North Carolina, there is no statewide system for managing access for individuals seeking waiver services (waiting lists). State agency staff reported that each county has its own system. Some counties require a basic pre-screening process to place a person on the waiting list, whereas other lead agencies put everyone on the list that asks to be placed there. When a person's name nears the top of the list, he or she completes the financial eligibility process as well as a medical/functional assessment and may be accepted to receive waiver services. This system does not allow for any management of the waiting list based on the needs of the individuals who would like to receive waiver services. It also does not take into account persons who are at high risk of institutionalization and could potentially be diverted prior to admission into a nursing facility by delivering waiver services.

One approach used by other states is giving individuals at risk of institutionalization "priority status" for waiver admission and expediting these assessments. A good example is Vermont's priority based system for the HCBS waiver waiting list. The policy, implemented in 1996, gives priority to four groups: (a) applicants who are in a nursing facility and wish to be discharged; (b) applicants in a hospital who wish to return to the community; (c) applicants in the community who are at risk of harm without waiver services; and (d) applicants at risk of moving to a more restrictive setting. State-designated agencies can perform initial assessments of applicants to determine if an individual falls into one of these categories.[53] Georgia's waiver program uses a phone screening tool (Gateway) that provides information for consumers about

[52] Traylor, C. "The Texas Promoting Independence Experience, Money Follows the Person 1999-present." Presentation to the CMS HCBS Waiver Conference. Milwaukee, WI. October 2003.

[53] Personal Interview with Joan Senecal, Principal Assistant to the Commissioner, Vermont, May 27, 2005; Vermont – Facilitating Nursing Home to Community Transitions. Promising Practices in Long Term Care Systems Reform, prepared by the Medstat Group for CMS, 2004.

services they may need, but also can be used to place individuals on the waiting list. However, at this time, the State uses a first-come, first-served process.

DMA notes that Several Division of Medical Assistance initiatives will address certain aspects of this issue. A uniform screening/assessment tool and the related automated business processes are currently being designed. This completed project will facilitate a central point of entry for all individuals in need of Medicaid long term care. Screening, medical eligibility, level of care, and prior approval will all be determined using an automated interface. This process would facilitate an "upfront" determination of long term care needs and the best options for meeting those needs.

Additionally, the CAP/DA clinical coverage policy is currently being amended to prohibit certain individuals from being placed on waiting lists including:

- CAP/DA clients transferring from other counties;
- Individuals transferring from other waiver programs (CAP/C and CAP/AIDS);
- Individuals being discharged from hospitals or nursing facilities; and
- Individuals transferring from Medicaid's Private Duty Nursing services.

Additional waiting list standards are also being considered.[54]

Bias #8: Inconsistent allocation of CAP/DA slots (State Policy/Administration)

Individuals may wait for waiver services in one county while other counties have unused waiver slots.

Recommendation:

Explore possibility of more active statewide management of waiver slots and waiting list. This could require legislation to appropriate additional funds to cover the activities to monitor wait lists.

To manage this limitation on the number of persons who can enroll in CAP, DMA assigns each county a certain number of CAP/DA slots. For every CAP slot, there is also an assigned maximum number of Medicaid dollars that can be used (for FFY 05 the estimated per capita limit is $19,679).[55] Budget decisions have had a major impact on the number of CAP/DA slots available since 2001. From October 1, 2001 to July 31, 2002, the state froze the program allowing no new participants on the waiver.[56] Two years later, on July 20, 2004, DMA notified the CAP/DA Lead Agencies of a statewide budget increase of $28 million for the program, and the addition of 2,500 new CAP/DA slots. The state also established a Slot Allocation Workgroup to determine how the 2,500 new slots would be allocated to the counties. The Workgroup established the methodology described below to allocate the new slots.

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54 DMA memo dated February 9, 2006 from Mark T. Benton to Theresa Matula.

55 CAP/DA approval letter from Hugh Webster, Acting Associate Regional Administrator, CMS, to Gary Fuquay, Acting Director, North Carolina Department of Health and Human Services, November 26, 2003.

56 CAP/DA: 2003, A report to the NC General Assemble. Durham, NC. North Carolina Institute of Medicine, February 2003.

- Step 1: The state added 163 of the new slots to some counties to increase their County Base Allocation to bring each county up to the county's definition, or count, of available slots.

- Step 2: The remaining 2,337 slots were distributed to the counties based on the percentage of the Medicaid aged, blind, and disabled recipients age 18 and older residing in each county.[57]

DMA expects lead agencies to fully utilize their slot allocations if possible. To monitor slot utilization, DMA requires each lead agency to submit a Slot Utilization Plan to DMA. The Slot Utilization Plan includes steps taken to use the additional slots, a 12-month plan of activities to fill slots, and a description of issues or barriers to utilizing slots. Lead agencies may refuse all or some of their slot allocation. DMA and the Slot Allocation Workgroup retain the right to reallocate slots if they find the lead agency is not meeting its Slot Allocation Plan. With the additional slots, the total number of 2004 waiver slots was 13,200.[58] The assigned slots for CAP/DA are also to be used for CAP/Choice.[59]

As of December 31, 2005, 1,900 CAP/DA slots were unused, although many counties currently have waiting lists for services. Waiting lists in each county vary greatly in size, ranging from 0 to over 1,000.[60] Lead agencies use different processes to manage their wait lists. For example, some lead agencies gather basic information about clients and then add their names to a waiting list and screen them when their names come to the top of the list. Others follow up periodically with persons on the wait list to ensure that the person is still interested and to determine whether there has been a change in his or her condition. Still others may conduct a pre-screening assessment (home visits or questionnaires) before adding individuals to the waiting list. The Workgroup did not use length of county waiting lists to determine slot need because there is not a standardized method for maintaining waiting lists.

North Carolina should explore the possibility of statewide management of waiver slots and the waiting list. This would allow individuals to receive services when they are qualified for the waiver and there are available waiver slots. If the state chose to take a more incremental approach, DMA could improve the system for redistributing slots among the counties. The state could, for example, require a standard process for adding individuals to the CAP/DA waiting list and periodic reports of the number of people joining the waiver and available slots in each area. The slots could be evaluated periodically on a statewide basis by DMA to assist with the redistribution process. This would require additional Medicaid administrative funds.

DMA staff expressed reluctance to realign unused slots, in part because it has not yet been the expected 18-24 months the workgroup thought would be necessary for all counties to effectively fill their slots and arrive at a desirable slot utilization level. They also noted additional program management activities currently being implemented which will impact recipients' entry to and

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57 Memorandum from Lynne Perrin to CAP/DA Lead Agencies on July 20, 2004. Re: New CAP/DA Slot Allocation for SFY 04-05.

58 McDuffie, J. (2004) *Assistance program to get additional slots; additional provider slot requested.* Bladen Journal. Available at: http://www.bladenjournal.com/articles/2004/08/17/news/business/business05.txt.

59 NC DHHS, Family & Children's Medicaid Change Notices. DATE Available at: http://info.dhhs.state.nc.us/olm/manuals/dma/fcm/chg/MA_CN11-05.htm

60 Office of the State Auditor. *Performance Audit of Community Alternatives Program for Disabled Adults*. State of North Carolina, October 2004.

discharge from the CAP/DA program, and therefore affect slot utilization. These include new efforts to closely monitor the medical eligibility of the individuals currently enrolled in CAP/DA to ensure that participants effectively meet the program criteria and receive services commensurate with their needs by reviewing newly available data from the recently implemented automated assessment, quality and utilization tool. DMA would like to complete this evaluation process and make final CAP/DA coverage policy changes before considering substantive changes to the slot allocation process. [61]

2. Payment Rates

No Bias Found: Long term care payment rates (State Policy)

The adequate supply of long term care providers in various settings and payment rates that account for varying care level needs suggests a well-functioning market system.

Lewin did not identify an institutional bias related to payment rates.

North Carolina has been revising its provider payment systems for long term care services over the past several years. The state instituted a "case-mix" system of reimbursement for nursing facilities and home health and is developing a similar system for CAP/DA. Case-mix systems pay higher rates for individuals who are assessed to need more resources. Personal care services are also segmented into two categories for payment purposes – basic and enhanced in adult care homes and regular and PCS Plus in individual's homes. This type of payment system incentifies providers to provide services to both light and enhanced care participants.

A recent report of the Adult Care Home Cost Modeling Committee found that North Carolina based its PCS reimbursement on 1.1 hours per resident per day. Further, they found that based on resident assessments, when compared to national studies, basic ACH residents indicated a need for 2.31 hours and specialized care unit (SCU) for people with Alzheimer's and related diseases resident requires 4.07 hours. [62] During the 2005 legislative session, the General Assembly increased the payment level for SCUs to the over four hours indicated in the report.

Despite the Modeling Committee's findings, we concluded that there was no institutional bias in payment rates. The abundant supply of adult care home beds offered suggests an adequate payment rate when the Special Assistance and PCS payments are combined.[63] Market theory would indicate tighter supply if payment rates were inadequate.

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[61] DMA memo dated February 9, 2006 from Mark T. Benton to Theresa Matula.

[62] Adult Care Home Cost Modeling Committee, *Report of the Findings and Recommendations of the Adult Care Home Cost Modeling Committee*, May 2005. http://www.dhhs.state.nc.us/ltc/ACHCostModelReport.pdf

[63] Because low income individuals with disabilities pay little for their room and board and personal care and are entitled to this care if they meet the eligibility requirements, unless adult care homes are considered an inferior good, we would expect demand to be high among those eligible. If this is the case, the low occupancy rate could indicate that all of the demand for adult care home services among low income individuals with qualifying disabilities has been met. Thus, an alternative explanation for the low occupancy rates is that the price adult care homes are charging consumers that must pay their own way is too high, thus demand is low.

D. Provider Regulation and Oversight

Provider regulation and oversight can contribute to an institutional bias if there are uneven requirements for providers in institutional settings in comparison to providers in community-based settings. This section reviews facility licensing rules, personnel licensing rules and staffing requirements, and quality monitoring and oversight at the state level.

In addition to requiring state licensure and certification, the Medicaid program requires that all providers enroll with the program. Enrollment requirements vary by provider type, but most providers must complete a North Carolina Medicaid Participation Agreement, provide verification of licensure, and a letter of certification as a Medicare provider from CMS. Providers must maintain the required licensure and accreditation to remain an active Medicaid provider.

After the initial licensing or certification process and enrollment process for Medicaid, the quality of health care providers and facilities is overseen by a number of entities. Again, in some cases, quality is monitored by both the state licensing or oversight agency and the Medicaid program, which is a primary purchaser of many long term care services.

These rules and regulations do not necessarily contribute to an institutional bias. There are reasonable clinical reasons why different types of providers have different licensing and oversight requirements. However, we reviewed the LTC facility and provider licensure and oversight rules to determine if an institutional bias could stem from these rules.

1. Facility Licensing

No Bias Found: Facility Licensing (Federal/State Policy)

North Carolina has more intense licensing requirements for facilities providing skilled care to Medicaid beneficiaries than for other providers. The care provided in skilled settings requires higher levels of education and training and more intense regulation is appropriate.

Lewin did not identify an institutional bias related to facility licensing.

The statutes governing North Carolina health care providers can be found in the North Carolina Administrative Code (NCAC).[64] The state agency responsible for the licensure, certification, and oversight of quality in all health care facilities and provider agencies is the Division of Facility Services (DFS) within DHHS. Long term care services, provided in institutions and or in the home or community, are regulated by the state, including:

[64] The North Carolina Administrative Code can be found at: http://ncrules.state.nc.us/default.htm under Title 10A, Department of Health and Human Services. Relevant subchapters include: Subchapter 13D, Nursing Homes; Subchapter 13F, Homes for the Aged and Disabled; Subchapter 13G, Family Care Homes; Subchapter 13J, Home Care Agencies; Subchapter 13K, Hospice Agencies; and Subchapter 14C, Certificate of Need.

- **Nursing facilities**: "Subchapter 13D -- Rules for the Licensing of Nursing Homes" of the NCAC includes the state requirements for nursing facilities. Nursing facilities must be managed under the direction of a nursing home administrator, who must be employed by the facility on a full-time basis. The facility must also employ a Medical Director (a physician) and a Director of Nursing (registered nurse). All professional staff must be licensed, certified, or registered in accordance with state laws.

  In addition, the regulation includes information on a variety of nursing facility administration topics, including the resident appeals process, standards for admission, requirements for patient assessment and care planning, safety requirements, and personnel standards. The regulation details quality of care requirements, medication administration processes, medical records maintenance, protocols for working with facility-employed and private physicians, dietary services, and other specific requirements.

- **Adult care homes and family care homes**: Adult care homes are congregate living arrangements for persons who have some support needs, but do not require skilled care. They are enrolled Medicaid providers of Basic and Enhanced Personal Care Services and non-emergent medical transportation. Rather, they Adult care homes are funded through state and federal funds and by the residents themselves. Residents may be eligible for State/County Special Assistance, which can offset the cost of room and board. DFS licenses and county departments of social services supervise adult care homes. County departments of social services are required to monitor facilities at least every two months.

  "Subchapter 13G – Licensing of Family Care Homes" includes the state requirements for these facilities. The physical plant requirements are similar for adult care homes and family care homes. For example, both are required to have bedrooms of no more than two residents, a toilet for every five residents, dining and living areas, storage areas, and appropriate furnishings.

- **Home health agencies**: In order to receive Medicaid reimbursement for services, home health agencies must be Medicare-certified and enrolled with DMA as a home health provider. Both skilled services (e.g., skilled nursing, physical therapy, speech-language pathology, occupational therapy) and aide services are available for persons living in a private residence. Skilled services are also available to persons in an adult care home or family care home.

- **Hospice agencies**: Hospice services can be provided in a number of settings, including the patient's home, a hospice residence, or an inpatient facility, such as a hospital or nursing home. For hospice residences, there are specific requirements governing the facility and staffing, outlined in Subchapter 13K of the NCAC.

- **Home care agencies**: In order to receive Medicaid reimbursement for CAP and personal care services, home care agencies must be licensed by the state. This involved either being accredited by any of the bodies specified in the Home Care Licensure Act (N.C. G.S. 131E 138) or passing a survey process.

2. Personnel Licensing and Staffing Requirements

The Health Care Personnel Registry includes information on both licensed and unlicensed personnel working in licensed health care facilities. Prior to legislative action in 1996, DHHS did not include unlicensed personnel. The Health Care Personnel Registry section within DFS reviews and determines if personnel comply with federal and state rules regarding training and competency evaluation.

No Bias Found: Personnel Licensing and Staffing Requirements (Federal/State Policy)

North Carolina staffing requirements for nursing facilities are more stringent than for other facilities. However, nursing facilities provide care to beneficiaries with, on average, higher acuity levels than in other settings.

Lewin did not identify an institutional bias related to personnel licensing and staffing requirements.

North Carolina has varying competency testing and other requirements depending on the type of setting. The state requires that all aides providing Level 3 Personal Care (nurse aides) in North Carolina pass a competency test and be listed on the Nurse Aide I Registry. Licensed staff who wish to be listed on nurse aide registry must submit documentation of current work history which has to be within the last 24 months and the individual must have a license to practice in the state. If the individual has not worked in the last 24 months, the individual needs to complete nurse aide training and competency evaluation. Facility or provider-specific requirements follow:

- **Nursing facilities**: The nursing home regulations (Subchapter 13D) outline the staffing requirements for nursing facilities. All nursing facilities must employ an administrator who is responsible for the nursing facility on a full-time basis. Nursing facilities must employ a medical director, who must be a physician, and a Director of Nursing, who must be a registered nurse. The nursing facility employs licensed nursing personnel to conduct patient assessments, patient care planning, and supervisory functions for

Nurse Delegation Rules

The North Carolina Board of Nursing identifies nursing care activities which may be delegated to unlicensed personnel (nurse aides). Delegating these activities to persons with fewer credentials allows the care to be completed for a lower cost. Because delegated tasks are required to be supervised by a registered nurse, however, there should be no reduction in the quality of the services provided. A Nurse Aide I can perform tasks as outlined in the rules for personal care (ADL assistance, nutrition, transfers, elimination and safety) after passing a state competency evaluation program. Nurse Aide II is a more advanced licensure status. A Nurse Aide II can perform some more complex nursing skills with an emphasis on sterile techniques (e.g., IV fluids, tube feeding, tracheotomy care). Both levels of nurse aides must be listed on the state's Nurse Aide Registry and a Nurse Aide II also must be listed with the Board of Nursing. These nursing care services must be delegated by a licensed registered or practical nurse, according to the appropriate to the level of knowledge and skill of the nurse aide. The nurse that delegates to the nurse aide must do so in accordance with the knowledge and skills of the aide, his or her clinical competence, and the stability of the client's condition.

residents. Nurse aides can complement the nursing staff. The facilities also employ additional professional and non-professional staff to provide for the health and safety of beneficiaries.

- **Adult care homes and family care homes**: In contrast to nursing facilities, there are minimal staff training and qualification requirements for adult care homes and family care homes. While they are similar in the services they offer, the requirements for staffing for the larger facilities are more comprehensive than for smaller facilities. For example, adult care homes require a food service coordinator and require that all personal care aides complete advanced training. Adult care homes must have an administrator who is over 21 years of age, a high school graduate or GED, with six months training in long term care or be a licensed health professional, and earn 12 hours per year of continuing education credits. Administrators in family care homes must be over 18 years of age, a high school graduate or GED, with three references, employed in a licensed facility for at least 30 days or demonstrate related education or training, and earn 15 hours per year of continuing education credits. Most staff are not licensed because staff primarily provide unskilled care and nurses can delegate and monitor certain tasks (see the box on nurse delegation rules).

- **Home health agencies**: Home health agencies provide skilled care in a home setting. As noted above, home health agencies may provide skilled nursing, physical therapy, speech-language pathology, occupational therapy, home health aide services, and medical supplies. These providers must be licensed to provide the related service. For example, skilled nursing providers must be a licensed registered nurse (RN) or licensed practical nurse (LPN) under the direction of a licensed RN. Physical therapy must be provided by either a licensed physical therapist (PT) or a licensed physical therapy assistant under the direction of a licensed PT. Speech-language pathologists must be a licensed speech-language pathologist or audiologist. Occupational therapy must be provided by a licensed occupational therapist (OT) or licensed occupational therapy assistant under the direction of a licensed OT. Social workers must also be licensed. Home health aide services must be provided by individuals who have been trained to provide them. The Medical Care Commission was authorized to adopt rules that address the staff qualifications and minimum training, education requirements, staffing levels and supervision for home care agencies, which will be inspected at least every three years.

3. Quality Monitoring and Oversight

Bias #9: Lack of Coordinated Effort to Assure Quality in the Community (State Administration/Local Operation)

Nursing facilities are accountable to quality oversight requirements at the federal and state levels, while home and community-based providers are not. While North Carolina has a variety of quality assurance mechanisms in place, there is no coordinated effort around assuring and improving quality in home and community-based settings.

Recommendation:

North Carolina Medicaid can help alleviate the problem by focusing attention on quality monitoring. This change may or may not require legislation and the appropriation of funds to cover greater quality oversight.

Monitoring quality can be difficult in HCBS settings because the state cannot rely on traditional quality measures that are used in institutional settings. The quality measures for institutional settings have historically relied on process measures, such as staff ratios and building specifications, although some quality indicators are linked to resident MDS data. There are economies of scale for monitoring institutions, which typically have a large number of residents, while community-based residential settings may have fewer than 6 people and there may be only one Medicaid beneficiary in an in-home setting. Further, there may be privacy considerations to conducting reviews in a person's home.

Most measures currently in use in community-based settings are related to provider qualifications (licensure), although recent efforts have focused on outcomes measures for persons receiving community-based care. In recent years, CMS has developed a Participant Experience Survey to measure program participants' experience with the services and supports they receive through HCBS waivers. Three versions of the survey are available for use by states – one for programs serving seniors and persons with physical disabilities a second for programs serving individuals with mental retardation/developmental disabilities and a third for adults with acquired brain injury.

There are a number of North Carolina departments and divisions and other agencies that monitor health care facilities and personnel (see ***Table 2*** for an overview for adult care homes). These activities take place on a periodic basis, some as specified in law or regulation (e.g., Medicaid nursing facility reviews on an annual basis), and others on an as needed basis. Differences in quality monitoring may contribute to an institutional bias if individuals receive a lower quality of care in some settings than others.

Medicaid requires and helps to fund the cost of annual quality reviews for nursing facilities. However, DFS oversees quality in adult and family care homes. Because of the high volume of adult and family care homes, tight state funding, and a small review staff, these facilities are monitored on a periodic basis – normally when a problem is reported. DHHS has been directed by the General assembly to implement annual monitoring for regulatory compliance and physical plant and life-safety inspections for licensed ACH requirements every two years by

July 1, 2007. In addition, this past legislative session, the General Assembly directed the Division of Aging and Adult Services to develop a star rating program for adult care homes, not tied to reimbursement. DAAS is also piloting a quality improvement project for adult care homes which will be implemented by county social services offices to supplement the monitoring of ACH facilities that occurs at least every two months for compliance with rules and investigate complaints.

Although quality in community-based settings is a system-wide issue not unique to the state, North Carolina can help alleviate the problem by focusing attention on quality monitoring. The Quality Improvement Organization (QIO) oversees the state's quality review program for the CAP/DA waiver, known as the Automated Quality Utilization and Improvement Program (AQUIP). AQUIP's goal is to identify opportunities for Medicaid systems improvements, which will ultimately result in better care North Carolina's CAP/DA program participants. AQUIP looks at program patterns and trends at an aggregate level, and aims to identify areas for progam change. The AQUIP review system gathers and assesses data in three areas: (1) level of care; (2) cost; and (3) quality. North Carolina's latest CAP/DA waiver renewal outlines several specific efforts the state is making to maintain quality in home and community-based settings, such as re-reviewing a sample of case records, working with the Medicaid program integrity unit to identify providers who may be delivering substandard care, and monitoring case managers to assure compliance with waiver requirements. These efforts represent a step forward in improving quality in the waiver.

As noted above, while quality may not, in fact, be higher in settings that are monitored more frequently, the simple fact that reviews are conducted may make an individual perceive that institutions have higher quality and may affect beneficiary choice of LTC settings. Enhancing quality reviews in home and community-based settings may level the playing field.

Table 2. Oversight of Adult Care Homes and Personnel

Department/ Division	Responsibility
Division of Facility Services (DFS)	Develops and implements policies and procedures governing the licensing and enforcement of rules and conducts facility surveys when indicated
Division of Aging and Adult Services (DAAS)	Administers Special Assistance program, protective services, civil rights programs, case management services, and resident assessment prior to admission. Also oversees the state's Long Term Care Ombudsman program which involves the following: o Long Term Care Ombudsmen - Resolve resident rights complaints. o Community Advisory Committees - Observe and report to the Division of Aging and Adult Services general conditions of homes on quarterly visits and assist residents in resolving grievances.
County departments of social services	Monitor facilities at least every two months for compliance with rules, investigate complaints, and provide case management services to eligible residents and resident assessment services prior to admission
Area Mental Health Programs	Provide services to clients placed from state mental institutions and from the community if they are included in area program service plans
Division of Medical Assistance (DMA)	Administers the Medicaid program which includes reimbursement for personal care and enhanced care case management services for adult care home residents
Local Building Inspectors and Fire Departments	Conduct safety inspections annually
Local Health Departments	Conduct sanitation inspections annually and more often to follow up corrective action
Home Health Agencies and Hospice	Provide service to individual residents upon physician orders and provider/family arrangement and often report observations to regulatory agencies
Occupational Health and Safety Administration (OSHA)	Inspects for compliance with its regulations which include those governing infection control

Source: http://www.dhhs.state.nc.us/ltc/adchsumm.htm.

4. Prior Approval Process

Although there is a (medical) assessment and prior approval process for entry into nursing facilities and for the CAP/DA waiver, North Carolina also requires prior approval for some services to safeguard against duplication of services, inappropriate services, and excess payment.

Bias #10: Prior Approval Process Delays Appropriate Care in the Community (State Policy)

Individuals in institutions acquire additional services easily when their needs change. For persons in home and community-based settings, prior approval is required for any change in the level of services provided, particularly in the CAP/DA waiver program.

Recommendation:

Develop simpler mechanisms for individuals to increase services when needed, especially on a temporary basis. This change would require legislation and the appropriation of funds to cover the potential increase in service use.

Outpatient therapies and private duty nursing services require prior approval. For the CAP/DA waiver, prior approval is required for every service included in the plan of care. For most other LTC services, a physician's written orders, as part of the individual's plan of care, are sufficient to authorize services.

Some specialized outpatient therapy services, including physical therapy, occupational therapy, speech-language pathology, audiological services, and respiratory therapy require prior approval by the QIO. The QIO determines if the beneficiary's medical condition and needs justify the frequency and intensity of service to be provided. There are no provisions for retrospective authorization of services for clients.

Private duty nursing (PDN) services require prior approval from the Home Care Initiatives (HCI) Unit at DMA. Patients must first receive a physician referral that identifies the need for PDN. The letter must contain information on: the diagnosis; date of hospital discharge if the patient is currently hospitalized; estimated amount, frequency, and duration of PDN needed; and the expected number of nursing interventions and their required frequency. DMA then assesses the appropriateness of the need for PDN using criteria developed by the HCI Unit. The agency then requests prior approval from the HCI Unit, which will approve the number of hours per day and days per week that PDN services may be provided to the patient. If the HCI Unit approves PDN, a letter is sent to the patient and attending physician informing them. The HCI Unit may also require an on-site assessment and schedule a visit with the patient.

In order to obtain CAP services, a Medicaid beneficiary must have a plan of care developed by a case manager at an approved local lead agency. The treatment plan contains approval for a specific amount, duration, and scope of services that are available in that program. CAP service providers are required to submit claims to the case manager for review and approval before submission to the state's claims processor.

Prior approval has been required for PCS Plus and enhanced PCS payments in adult care homes. Until recently, regular PCS in both adult care homes and individual's homes required physicians to submit a form certifying and authorizing treatment, but these forms did not require third party prior approval. The recent legislative session initiated a review of all PCS-In Home clients and a new system of approval that includes a requirement that PCS providers obtain the physician's signature on the PACT form within 60 days of the verbal or written order which authorized services to begin. The PACT forms must be completed by a RN representing

the PCS provider and who has demonstrated program competency through a DMA training program. The PACT form is to be completed based on an in-home, face-to-face PCS assessments.

IV. COST ESTIMATES

At the request of the Study Commission, DMA estimated the cost of covering the Medicare Part D drug copays of CAP/DA recipients.

Bias #1: Federal provision to reimburse Medicare Part D prescription drug copays for nursing facility residents (federal policy).

Recommendation: *Addressing this bias would require a change in federal legislation or legislation authorizing state revenue to cover the copays by the North Carolina Assembly.*

DMA reports that 11,547 CAP/DA recipients received Medicare benefits during SFY 2005 and estimate he cost of covering the copays for their nearly 800,000 prescriptions at $2.39 million.

The Lewin Group estimated the potential cost to Medicaid for three of the recommendations selected by DMA.

Bias #2: Lack of simplified access and consistent support coordination system.

Recommendation: *Study ways to improve efficiency and effectiveness of case management.*

The estimated cost of a study of case management based on a literature review and an examination of practices in up to five other states would be between $30,000 and $50,000.

Bias #3: Medically needy requirements leave little money for persons to pay for living expenses if they prefer to remain in the community, while institutions provide room and board.

Recommendation: *Increase medically needy income standard from the current monthly standard of $242 to a level at least the national medically needy average ($416 for single individual).*

The 2003 IOM Report recommended that the medically needy limit be increased to 100 percent of the poverty level.[65] The estimated state revenue to support this increase for SFY2002 and SFY2003 was $43.1 million and $48.7 million, respectively. In 2002, when the IOM estimates were developed, 100 percent of the poverty level for a single individual was $738 per month, or $496 greater than the current medically needy limit. Increasing the medically needy limit to the national average would increase the medically needy limit $174.

In estimating the cost of an increase in the medically needy limit to the national average, we accounted for two components: 1) the increase to Medicaid for the existing medically needy recipients that would retain an additional $174 per month; and 2) the increase in the number of individuals eligible for Medicaid.

Approximately 43,000 Medicaid recipients in North Carolina qualify as a result of spending down to the medically needy limits. Using an average enrollment of eight months, the cost associated with allowing existing medically needy individuals to retain an additional $174 per

[65] North Carolina Institute of Medicine, Community *Alternatives Program for Disabled Adults (CAP/DA):2003. A report to the NC General Assembly*. Durham, NC: February 2003. http://www.dhhs.state.nc.us/ltc/ltcc5.htm#28

month would be between $50 and $60 million total with the state share of Medicaid constituting $20 to $23 million.

The increase in the number of individuals eligible for Medicaid as a result of a higher medically needy limit is more difficult to estimate because it requires information about the distribution of expenditures for individuals with high medical costs who do not qualify for Medicaid based on other criteria. Assuming an additional 10 percent of North Carolina residents would qualify for Medicaid under a higher medically needy limit adds an additional $85 million to program costs with the state share of Medicaid constituting $32 million.

The two components of the costs combined would result in state expenditures between $52 and $55 million in SFY2006.

Bias #4: Differences in spousal impoverishment rules can create hardships for families if a spouse prefers home or community-based care over institutional care.

Recommendation: *Align spousal impoverishment income rules for LTC beneficiaries in all settings.*

Increasing the spousal impoverishment provisions for CAP/DA participants to 150 percent of the poverty level would only affect those married couples where the CAP/DA participant's income is greater than their spouse's and they qualify for CAP/DA as a result of medically needy spenddown. Less than eight percent of CAP/DA participants are married and only a subset of these qualify based on medically needy provisions. Changing the spousal impoverishment provision would likely affect less than 50 current CAP/DA recipients at a cost of less than $300,000 total and $113,000 for the state share of Medicaid.

V. SUMMARY AND CONCLUSION

In this report, Lewin examined the policies and related administrative practices that may generate a bias for the use of institutional services over home and community-based services, and addressed potential federal, state, and local policy changes that may be necessary to alleviate any identified bias. Although this report identified some instances of bias in North Carolina's LTC system where there could be significant changes outlined in ***Table 3***, overall, the state's policies and practices appear to support individual choice between institutional and home and community-based setting. In fact, there were six areas where no bias was found:

Table 3. Summary of Biases and Recommendations

Bias Number	Identified Bias	Type	Recommended Action	Would legislative policy change be required?	Cost Estimate[66]
Medicaid Long Term Care Benefits					
1.	Federal provision to reimburse Medicare Part D prescription drug copays for nursing facility residents, but not for home and community-based waiver participants.	Federal policy	Advocate for a change in federal legislation or provide coverage for Part D copayments for CAP/DA participants through state funds.	General Assembly would need to appropriate funding.	$2.4 million *(DMA estimate)*
Availability and Accessibility					
2.	Lack of simplified access and consistent service coordination system.	State administration/ local operation	Study ways to improve efficiency and effectiveness of case management.	No change in policy.	$30,000-$50,000
3.	Medically needy requirements leave little money for persons to pay for living expenses if they prefer to remain in the community, while institutions provide room and board.	State policy	Increase medically needy income standard from the current monthly standard of $242 to a level at least the national medically needy average ($416 for single individual).	Amend the Medicaid State Plan. This change would require state legislation to change the medically needy limit and appropriate funds to cover the increased costs.	$52-$55 million
4.	Differences in spousal impoverishment rules can create hardships for families if a spouse prefers home or community-based care over institutional care.	State policy	Align spousal impoverishment income rules for LTC beneficiaries in all settings.	Amend the Medicaid State Plan. This change would require state legislation to appropriate funds to cover the increased costs.	$113,000

[66] The Lewin Group's contract included estimating the cost of three recommendations. DMA prioritized the recommendations for the cost estimates.

Table 3. Summary of Biases and Recommendations

Bias Number	Identified Bias	Type	Recommended Action	Would legislative policy change be required?	Cost Estimate[66]
Cost Containment					
5.	Application of federal waiver cost neutrality requirement.	State administration	Develop mechanism to allow for high cost individuals to have the opportunity to receive care in the community, either through exceptions to the budget cap or a new system of approval perhaps based on the CAP/C program. This may require additional coordination across counties/lead agencies.	Change CAP Medicaid eligibility guidelines in CAP/DA Manual and other program instructions. This change may or may not require state legislation.	Not estimated
6.	Enrollment caps limit number of people who can access care in the community.	State policy	Develop a financing mechanism that allows flexibility to increase CAP/DA slots.	Change budget structure for Medicaid LTC. This change would require state legislation to increase the enrollment caps and funds to cover the increased costs, as well as federal approval.	Not estimated
7.	No differentiation of need on the CAP/DA wait lists.	State administration/ local operation	Create a priority list for waiver admission for persons at risk of institutionalization or who are institutionalized.	No change in policy. This could require state legislation for the appropriation of funds to cover the activities to prioritize the wait lists. However, better targeting of individuals who might otherwise be institutionalized could save NF costs.	Not estimated
8.	Individuals may wait for waiver services in one county while other counties have unused waiver slots.	State administration	Explore possibility of more active statewide management of waiver slots and waiting list.	No change in policy. This could require state legislation to appropriate funds to cover the activities to monitor wait lists.	Not estimated

Table 3. Summary of Biases and Recommendations

Bias Number	Identified Bias	Type	Recommended Action	Would legislative policy change be required?	Cost Estimate[66]
Provider Regulation and Oversight					
9.	Lack of coordinated effort to assure quality in the community	State administration/ local operation	North Carolina Medicaid can help alleviate the problem by focusing attention on quality monitoring.	This change may or may not require state legislation to change the state's authority and appropriate funds to cover greater quality oversight.	Not estimated
10.	Prior Approval process delays appropriate care in the community	State policy	Develop simpler mechanisms for individuals to increase services when needed, especially on a temporary basis.	This change would require state legislation to change the prior approval process and appropriate funds to cover the potential increase in service use.	Not estimated

- Medical/Functional Eligibility for Medicaid Long Term Care Services
- Provider capacity appears adequate in HCBS
- Certificate of Need program appropriately limits provider supply
- Long term care payment rates
- Facility Licensing
- Personnel Licensing and Staffing Requirements

North Carolina has applied for and received an array of federal grants all aimed at increasing the likelihood that older adults and those with life-long disabilities will have greater opportunities in the community. Grants include a Medicaid Infrastructure Grant aimed at improving employment opportunities and enhanced access to health care for working persons with disabilities, an Aging and Disability Resource Center grant aimed at creating a "single point of entry" for information on and access to LTC services and planning services, as well as an array of Systems Change Grants.

Although this report focused on the Medicaid program and policies and implementation practices that contribute to an institutional bias, it is worth noting that the shortage of availability of affordable, accessible housing options has a profound impact on the ability of individuals to choose home or community-based care. Consumers and state agency staff in North Carolina noted the lack of affordable accessible individual housing in the State is an important barrier to home and community-based care. Other states have been making efforts to assuage this concern by funding housing registries, requiring the development of affordable and accessible housing, and connecting beneficiaries with publicly-funded housing programs. Lewin recommends that North Carolina Medicaid work with federal and state housing authorities to identify and improve accessible housing options for persons with disabilities.

Between FY 2000 and FY 2005, the state increased the proportion of Medicaid LTC spending on home and community-based care (HCBS for aged and disabled, waivers, personal care, and home health) in comparison to institutional spending from 35.5 to 41.4 percent for older adults and people with physical disabilities.[67] The national average for home and community-based spending on older adults and adults with physical disabilities was 25 percent in FY 2004, indicating North Carolina is ahead of the curve in this area.

[67] Unpublished Medicaid data for State Fiscal Year 2005 provided by the North Carolina Division of Medical Assistance, November 2005.

Appendix A
Interview Participants

Appendix A
Key Informant Interviews

State Staff Interviews
April 6-7, 2005

Department of Health and Human Services
Jackie Sheppard
Assistant Secretary of the DHHS for Long Term Care and Family Services

Division of Medical Assistance
Jess Berman, Health Policy Analyst
Julie Budzinski, Adult Care Home Policy Consultant
Margaret Comin, RN, Facility Unit Manager
Pat Jeter, Section Chief for Rate Setting
Marjorie Morris, Medicaid Eligibility Unit Chief
Lynne Perrin, Section Chief – Facility and Community Care
Linda R. Perry, RN, Long-term Care Nurse Consultant
Teresa Piezzo, Supervisor Home Care Initiatives
Rosalie Wachsmuch, Supervisor CAP/DA, ACHs, PCS
Andy Wilson, Project Coordinator

Division of Aging and Adult Services
Mary Bethel, Special Assistant
Heather Burkhardt, Information and Assistance Program Specialist
Karen Gottovi, Division Director
Suzanne Merrill, Adult Services Section Chief
Geoff Santoliquido, State/ County Special Assistance Program Administrator
Dennis Streets, Planning, Budget & System Supports Section Chief

Division of Facility Services
Bob Fitzgerald, Director

Provider Interviews
April 7, 2005

Mary Rollins, Pediatric Services of America
Janice Honey, Pathways
Sherry Thomas, Association for Home and Hospice Care of NC
Jerry Cooper NC Assisted Living Association
Tim Rogers, Association for Home and Hospice Care of NC
Tom Mylett, Private Duty Nursing
Jim Edgerton Association for Home and Hospice Care of NC
Keith Arbuckle, Home Health
Donna Turlington, Liberty Home Care
Ann Farmer, Duke University
Steve Smith, Interim Health Care
Cheryl Atkinson, Carolina Health Services
Jane Dawson, Carolina Health Services
Stacey Flannery NC Health Care Facility Association
Lou Wilson, North Carolina Association of LTC Facilities

Department of Health and Human Services (DHHS)
Jackie Sheppard, Assistant Secretary of the DHHS for Long Term Care and Family Services

Nursing Facility Transitions Grant (NFTG)
Linda Kendell Fields, NFTG Project Director

Division of Vocational Rehabilitation/Independent Living (VR/IL)
Michael Howard, Transitions Manager, VR/IL
Donna Lovill, VR/IL, Charlotte
Marilyn Harvey, VR/IL, Raleigh
Anita Williams, VR/IL, Fayetteville
Beth Newcomb, VR/IL, Rocky Mount
Tammy Longmire, VR/IL, Rocky Mount
Ron Graham, VR/IL, Durham

Division of Medical Assistance
Larry Nason

Centers for Independent Living (CIL)
Bart Floyd, Western Alliance CIL, Asheville
Barbara Davis, Pathways CIL, Sylva
Rene Cummins, CIL, Raleigh

Consumers
Ruth Haines
Hyacinth Kabisa

Division of Aging and Adult Services, DHHS
Denise Rogers, Ombudsman Program
Chris Urso

MS Society
Abby Carter Emanuelson
Mary Shackelford

Association for Home and Hospice Care
Jim Edgerton

Interviews with Comparison States
December 2005

Florida Agency for Health Care Administration
Wendy Smith, Administrator Bureau of Medicaid Services
Keith Young
Regina Glee

Georgia Health Policy Center, Andrew Young School of Policy Studies, Georgia State University
Glenn Landers, Senior Research Associate

Memorial Health University Medical Center
Norma Jean Morgan, CEO, former Georgia Medicaid Long Term Care Director

Appendix B
North Carolina Medicaid Benefits and Limitations

Benefit	Description	Limitations	Medical Criteria and Prior Approval Process
Nursing facility services Mandatory Medicaid benefit Provided in an institution	Medicaid requires nursing facilities to offer the full range of services to residents who meet the level of care criteria for them. Nursing facility services include room and board, therapeutic leave, non-prescription drugs, biological serums and vaccines, physical therapy, speech pathology, occupational therapy, diagnostic services, social services related to the resident's physical, mental, and psychosocial well being, activity services to meet physical, mental, and psychosocial needs, personal laundry, routine room, dietary, medical and psychiatric services, medical supplies, personal hygiene items, medical equipment (canes, walkers, etc.), and dietary supplements.[1]	The nursing facility has different levels of care depending on the extent of the resident's need. Services must be provided in accordance with the comprehensive assessment and plan of care.	In order to be eligible for these services in North Carolina, an individual must meet the nursing facility level of care (LOC) criteria, as certified by a physician.[2] Certain medical necessity requirements must also be met to qualify for nursing facility services. These include a demonstrated medical disorder or disease that limits recognition, requires more than the routine care given by an untrained person, and requires nurses' supervision available only in an institution.
Home health services Mandatory Medicaid benefit Provided in the home or community	Home health services include part-time or intermittent nursing services provided by a home health agency, home health aide services provided by a home health agency, personal care, medical supplies, equipment, and appliances suitable for use in the home.[3] Home health care may be provided on a short–term intermittent basis and must be provided by Licensed Medicare Certified Home Health Care Agencies. Physical therapy, occupational therapy, speech pathology, and audiology services are optional services provided by a home health agency or state licensed facility to provide medical rehabilitation services.[4]	The amount of services available is limited to what is determined as medically necessary. For example, skilled nursing and home health aide services can only be received on a part-time or intermittent basis. Also, a patient who is receiving hospice or personal care services may not receive home health aide services on the same day.	Home health services do not require prior approval by the State, with the exception of occupational therapy, physical therapy, and speech therapy. A physician must authorize home health services and provide signed, written orders that detail the needed services. Home health nurses or other qualified health professionals may assist in developing the plan of care. The home health agency then assesses the appropriateness of care and begins delivery. CCE is responsible for the prior approval process for occupational therapy, physical therapy and speech therapy exceeding six visits. The home health agencies send forms to Medical Review of North Carolina, which responds with approval or disapproval.[5]

Benefit	Description	Limitations	Medical Criteria and Prior Approval Process
Personal care services Optional Medicaid benefit Provided in the home or community	Personal care services (PCS) are provided in private residences and includes hands-on or cueing assistance to patients to help perform certain tasks, often relating to the ability of the patient to perform activities of daily living (ADLs) and instrumental activities of daily living (IADLs), such as eating, bathing, dressing, toileting, transferring, personal hygiene, light housework, and medication management.[6] Housekeeping and home management tasks that are essential, although secondary, to the personal care tasks necessary for maintaining the patient's health, are also covered. Personal care services can be provided on a continuing or episodic basis. Case Managers working either for the county Departments of Social Services or the Local Management Entities provide prior approval for the enhanced personal care services and initiate a relationship to provide case management services to those residents for whom they approve the enhanced personal care.	In North Carolina, eligible individuals residing in private residences may receive no more than 3.5 hours per day and a total of 60 hours per calendar month of regular PCS. These services must be provided by a qualified individual who is not a member of the individual's family.[7]	Up until November 1, 2005, authorization for regular PCS services is provided by a physician as part of a written plan of care.[8] As of November 1, 2005, those seeking PCS must: 1) require assistance with a minimum of two unmet activities of daily living (ADLs), have no one else available to provide assistance, and have the ADL limitations addressed in the plan of care; and 2) have a medical condition that requires the direct and ongoing care of his/her primary physician prescribing PCS, but that is medically stable. A provider agency RN assesses the patient's medical condition and home environment and evaluates the person's need for PCS. The RN documents the findings in the assessment portion of the DMA-3000 Physician Authorization for Certification of Treatment (PACT) form. The patient's physician will then review the RN's assessment and the plan of care and decide if PCS is appropriate. If it is, the physician certifies the need for PCS and authorizes its delivery according to the plan of care.[9]

Benefit	Description	Limitations	Medical Criteria and Prior Approval Process
Personal Care Services Plus Optional Medicaid benefit Provided in the home or community	PCS beneficiaries with more intense needs, who meet eligibility requirements for PCS-Plus, may receive up to 20 additional hours of services each month, making their monthly service limit 80 hours.[10]	In order to be eligible for PCS-Plus services, individuals must meet one of the following criteria: 1) require extensive assistance in four or more ADLs, or 2) require extensive assistance in three or more ADLs, and need the in-home aide to perform at least one task at the Nurse Aide II level (more advanced). 3) require extensive assistance with three or more ADLs and have a medical or cognitive impairment that requires extended time to perform needed in home aide tasks. The identified needs must be met by the plan of care.	PCS providers must obtain prior approval from DMA before initiating services. PCS-Plus prior approvals are issued by the DMA PCS-Plus nurse consultant if individuals meet the requirements for PCS-Plus.[11] PCS-Plus is part of the pre-approved plan of care if additional care is needed, and then the extra hours of care will be provided.

Benefit	Description	Limitations	Medical Criteria and Prior Approval Process
Private duty nursing Optional Medicaid benefit Provided in the home or community	Private duty nursing (PDN) is a service provided for beneficiaries who require additional individualized continuous, substantial and complex nursing interventions not available through regular nursing services.[12] Private duty nurses provide care to beneficiaries on a regular basis to supplement nursing services already received through other means. PDN services can be provided by a registered nurse (RN) or licensed practical nurse (LPN), under the direction of and approval of a physician, at the beneficiary's home. Some states require that services be provided through home health agencies, while others enroll and directly reimburse nurses independently for these services. In North Carolina, private duty nursing is provided through home care providers.[13] Often, beneficiaries receiving PDN require technology to survive, such as mechanical ventilation or assisted respiration, frequent oral or tracheotomy suctioning, or nasogastric tube feedings or medications.[14]	In North Carolina, there is no limit on the number of hours of PDN available to recipients, as long as it is medically necessary. PDN may not be administered while personal care services, skilled nursing visits, or home health aide visits are being provided. A recipient receiving hospice under Medicaid cannot receive PDN for the treatment of a terminal illness. The recipient must choose between PDN and hospice for end of life treatment. In addition, a recipient of PDN cannot receive home infusion drug therapy, but can receive home infusion nutrition therapy while receiving PDN services.[15]	Private duty nursing services require prior approval from the Home Care Initiatives Unit at DMA. Patients must first receive a physician referral that identifies the need for PDN. The letter must contain information on: the diagnosis; date of hospital discharge if the patient is currently hospitalized; estimated amount, frequency, and duration of PDN needed; and the expected number of nursing interventions and their required frequency. DMA then assesses the appropriateness of the need for PDN using criteria developed by the HCI Unit. The agency then requests prior approval from the HCI Unit, which will approve the number of hours per day and days per week that PDN services may be provided to the patient. If the HCI Unit approves PDN, a letter is sent to the patient and attending physician informing them.[16]

Benefit	Description	Limitations	Medical Criteria and Prior Approval Process
Personal care services in adult care homes and family care homes Personal care services delivered by authorized adult care homes is an optional Medicaid benefit Provided in the community	Adult care homes are category of facility that provides 24-hour supervision and services for people needing assistance with activities of daily living (ADLs) due to normal aging, a chronic illness, a cognitive disorder, or a disability. There are over 2,000 adult care homes in North Carolina that range in size from two to six residents, to more than 100 residents.[17] Homes with fewer than seven residents are referred to as family care homes. People in adult care homes receive help with personal care, such as dressing, grooming, and medication management, and require limited supervision. If patients are eligible for an enhanced payment as a enhanced care resident, they may receive extensive or total assistance in ambulation/locomotion, toileting and/or eating. Adult care homes receive a higher reimbursement for these residents.	According to rules set by the NC Social Services Commission, adult care homes are inappropriate for certain individuals. These include patients who are dependent upon a ventilator, patients requiring continuous licensed nursing care, when the personal assistance and supervision offered for the aged and disables are not needed; or who pose a direct threat to the health and safety of others, and patients whose physicians have certified that such placement is no longer appropriate. Additionally, no one will be admitted for treatment for mental illness, or alcoholism or drug abuse or for maternity care shall.[18]	To gain admission into adult or family care homes, a resident must need supervision with at least one ADL and/or medication administration due to normal aging, chronic illness or a cognitive disorder or disability. They must not require medical intervention. To gain admission to an Adult Care Home, the potential resident's physician must certify the need for that level of care by completing the required FL-2 form. Once admitted there is no prior approval process for Basic Personal Care services. Prior approval is, however, required for the Enhanced Personal Care Services when referral documents, including the 3050R with physician's signature are sent to the county LME or Department of Social Services for assignment of a case manager. The case manager does a face to face evaluation and sends a decision notice to the resident and the facility management if denied and if approved sends it also to the Medicaid fiscal agent. The case manager then becomes involved in visiting the resident and helping the resident, family and facility meet any unmet needs through community resources.

Benefit	Description	Limitations	Medical Criteria and Prior Approval Process
Hospice Services Optional Medicaid benefit Provided in the home or community	Hospice focuses on palliative care and symptom management as opposed to aggressive, curative treatments. Hospice services can be provided at home, in the nursing facility, hospice facility, or hospital, and help patients manage their terminal illness by addressing the physical, psychosocial, and spiritual needs of patients and their families. Services include comfort care, pain management, respite, spiritual counseling, nursing care (generally intermittent with 24-hour on call), physician services, volunteer, and medical social services.[19]	In North Carolina, hospice care is a Medicaid benefit covered for two 90-day periods, followed by an unlimited number of 60-day periods. These periods may be used consecutively or at different times as long as the patient is certified as terminally ill and appropriate for hospice care at the beginning of each benefit period. A patient may choose to cancel hospice care at any time for any reason. However, if the patient is no longer considered terminally ill with a prognosis of six months or less, or if he/she no longer resides in the hospice agency's defined geographic service area, then the hospice agency may discharge the patient from hospice care. [20]	Hospice care is provided to individuals who are in the final stage (six months or less) of their lives due to a terminal illness. The initial hospice certification requires two signatures, the patient's attending physician and the medical director of the hospice agency, and then re-certifications only require one physician signature, usually the medical director of the hospice agency.[21] To receive hospice services an individual must first receive a referral from a physician, hospital discharge planner, or social worker. A hospice agency will then provide an interdisciplinary team that will visit the patient and assess the appropriateness of hospice care. If the hospice is appropriate, the patient will sign a Medicaid Hospice election statement that includes the patient's intent to receive hospice and their acknowledgement of the services they will receive. The hospice agency then calls the EDS prior authorization unit to report the individual's hospice participation. The hospice interdisciplinary team then develops the plan of care, with a nurse or physician's participation. Physician certification of the patient's terminal illness is needed within two days of the start of services in order for the state to pay the hospice claims.[22]

Benefit	Description	Limitations	Medical Criteria and Prior Approval Process
CAP/DA HCBS waiver Provided in the home or community	The CAP/DA waiver supplements home and community based benefits available through the Medicaid State Plan. Benefits include in-home aide services (such as housekeeping, laundry, essential shopping, assistance with eating, dressing, and bathing), medical supplies, case management, home mobility (wheelchair ramps, safety rails, grab bars), meal preparation and delivery, adult day health, respite care, and telephone alert services.	Waiver participants must meet the nursing facility level of care criteria. If approved for waiver participation, beneficiaries receive coverage for the care they need and are not being confined to any maximum budget of allowed coverage. Beneficiaries with approved skilled services will receive payments for the services they need, even though it may be in excess of intermediate care services required and received by other beneficiaries. There are also some individual service limits in the plans, such as a limit of up to $1,500 per fiscal year for home mobility aids, and up to 30 available days of respite care per fiscal year.[23] If a client is institutionalized (hospitalization or nursing facility admission), then any CAP/DA service used during that time may not be billed to the waiver.	Prior approval in the CAP/DA plan of care is required for each CAP/DA service provided to the client.[24] A case manager is in charge of assessing the CAP/DA participant's needs. Prior approval of the CAP/DA plan of care from county lead agencies on behalf of DMA is also required for each CAP/DA service to be provided to the client.
CAP/Choice HCBS waiver Provided in the home or community	The CAP/Choice waiver offers the same benefits as CAP/DA, but under this waiver, services can be consumer-directed.	CAP/Choice is available for two levels of care depending on the client's needs. These are: 1) intermediate directed care, CAP/Choice for intermediate care facility LOC, and 2) skilled directed care, CAP/Choice for skilled nursing facility LOC.	The eligibility requirements for CAP/Choice are the same as those for CAP/DA.

[1] Code of Federal Regulations, 42CFR440.155 specifies nursing facility services for Medicaid. North Carolina specific requirements are contained in the North Carolina Nursing Home Facilities Manual. Available at: http://www.dhhs.state.nc.us/dma/nursingfacility.htm

[2] Addendum A to Medicaid North Carolina Annual Report 2003, How the NC Medicaid Program Works.

[3] The Kaiser Commission on Medicaid and the Uninsured, Medicaid Benefits, Home Health services. Available at: http://www.kff.org/medicaidbenefits/homehealth.cfm

[4] Code of Federal Regulations, 42CFR440.70 outlines federal rules for home health services.

[5] NC DHHS, DMA Community Care Provider Manual, Section 05 Home Health Services. Available at http://www.dhhs.state.nc.us/dma/cc/5.pdf

[6] CMS, Personal Care Services. Available at: http://www.cms.hhs.gov/medicaid/services/pcserv.asp

[7] Code of Federal Regulations, 42CFR440.167 defines federal rules for personal care services.

[8] Ibid.

[9] NC DHHS, DMA Community Care Provider Manual, Section 06 Personal Care Services. Available at http://www.dhhs.state.nc.us/dma/cc/6.pdf

[10] NC DHHS, DMA, Long Term Care in North Carolina, Optional Services, Personal Care Services. Available at: http://www.dhhs.state.nc.us/ltc/invntry/4dma.htm

[11] DMA, Personal Care Services-Plus. Available at: http://www.dhhs.state.nc.us/dma/cc/3J.pdf

[12] Code of Federal Regulations, 42 CFR 440.80 defines private duty nursing services.

[13] On-line Addendum A to NC Medicaid SFY 2001 Annual Report, How the NC Medicaid Program Works. Available at: http://www.dhhs.state.nc.us/dma/2001report/howprogworks.pdf

[14] The Kaiser Commission on Medicaid and the Uninsured, Medicaid Benefits, Private Duty Nursing Services. Available at: http://www.kff.org/medicaidbenefits/privateduty.cfm

[15] Adult Medicaid Manual MA – 2905: Medicaid Covered Services. XXII. Private Duty Nursing (PDN). Available at: http://info.dhhs.state.nc.us/olm/manuals/dma/abd/man/MA2905-21.htm#P1077_40474

[16] North Carolina Community Care Provider Manual, Section 09 Private Duty Nursing Manual Available at: http://www.dhhs.state.nc.us/dma/cc/9.pdf

[17] NC Division of Aging and Adult Services, Adult Care Homes. Available at: http://www.dhhs.state.nc.us/aging/agh.htm

[18] McCann, M.J., Legal Services Developer, Elder Rights Section, North Carolina Division of Aging. (1998) "*Know Where You Are Going and What to Expect Before You Get There.*" The Forum for Family & Consumer Issues, NC State University. Vol.3, No.1.

[19] Code of Federal Regulations, 42 CFR 418.50 outlines federal rules. North Carolina rules provided by the Association for Home and Hospice Care of NC. Available at: http://www.homeandhospicecare.org/consumer/hospicecare.html

[20] NC DHHS, DMA Community Care Provider Manual, Section 08 Hospice. Available at http://www.dhhs.state.nc.us/dma/cc/8.pdf

[21] Association for Home and Hospice Care of NC. Available at: http://www.homeandhospicecare.org/consumer/hospicecare.html

[22] NC DHHS, DMA Community Care Provider Manual, Section 08 Hospice. Available at http://www.dhhs.state.nc.us/dma/cc/8.pdf

[23] Ibid.

[24] CAP for Persons with AIDS. Available at: http://www.dhhs.state.nc.us/dma/cc/10.pdf

Appendix C
Individual Medicaid Medically Needy Limits by State, 2002

Appendix C:

State	Medically Needy Limits - Individual	Notes
Louisiana	$100.00	
Arkansas	$108.33	
Florida	$180.00	
West Virginia	$200.00	
Kentucky	$217.00	
Tennessee	$241.00	
North Carolina	$242.00	
Illinois	$283.00	
Maine	$315.00	
Virginia	$345.12	
Maryland	$350.00	
New Jersey	$367.00	
Utah	$382.00	
Nebraska	$392.00	
Michigan	$408.00	**Average**
Hawaii	$418.00	**$416**
Pennsylvania	$425.00	
Kansas	$475.00	
Minnesota	$482.00	
Iowa	$483.00	
North Dakota	$500.00	
Massachusetts	$522.00	
Montana	$525.00	
New Hampshire	$566.00	
Washington	$571.00	
Connecticut	$476.19	**Regions B&C**
Wisconsin	$591.67	**Region A $574.86**
California	$600.00	
New York	$642.00	
Rhode Island	$650.00	
Vermont	$825.00	
Alabama	n/a	
Alaska	n/a	
Arizona	n/a	
Colorado	n/a	
Delaware	n/a	
District of Columbia	n/a	
Georgia	n/a	
Idaho	n/a	
Indiana	n/a	
Mississippi	n/a	
Missouri	n/a	

State	Medically Needy Limits - Individual	Notes
Nevada	n/a	
New Mexico	n/a	
Ohio	n/a	
Oklahoma	n/a	
Oregon	n/a	
South Carolina	n/a	
South Dakota	n/a	
Texas	n/a	
Wyoming	n/a	
Average	**$415.56**	

n/a -- State does not have a Medicaid Medically Needy program and is not included in the calculation.

Note: Connecticut uses a different MNIL for different regions of the state. For this calculation, we used the amount used in Regions B (Hartford) and C (New Haven). Region A is Fairfield. (2004 MNIL rates are close to the $476 used above and can be found at http://www.cga.ct.gov/ph/medicaid/mmcc/HUSKY/HUSKYProgramChanges200403.htm)

Source: American Public Human Services Association (APHSA), Center for Workers with Disabilities website (http://www.aphsa.org/disabilities/center_initiatives/abd.htm). Data were collected in 2002.